GENDERED RESEARCH IN HEALTH

A MANUAL

SAHAJ - SOCIETY FOR HEALTH ALTERNATIVES

VADODARA

WOMEN'S HEALTH TRAINING, RESEARCH AND ADVOCACY CELL – WOMEN'S STUDIES RESEARCH CENTRE

MAHARAJA SAYAJI RAO UNIVERSITY, VADODARA

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Published by : SAHAJ,Vadoda **ary 2009**

Printed by: INDRAM ENTERPR **Usha Patel**

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A MANUAL

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SECTION I

Introduction

Why Gendered Research in Health?

Gender bias in research

Most health related research continues to be carried out within the biomedical tradition. Although social factors affecting health are beginning to be considered seriously, a large proportion of resources are still spent on projects falling under the domain of biomedicine. Most health research continues to state that men and women are physiologically similar in all respects except their reproductive system. Traditional frameworks for analyzing women's health have often concentrated only on their childbearing years. The problems related to pregnancy and childbearing were considered important domains in women's health. Other biological differences and social differences affecting women's health are ignored. As a result both preventive and curative strategies are often applied to women when they have only been tested on men. There is growing evidence that sex and gender differences may be important in a range of health issues.

To change the inequalities in health research, women's needs and desires must have a more prominent place in the research process. A formal set of policies will be needed to ensure that their interests are represented.

Lack of sex disaggregated data

The basic problem with policy makers is the lack of information on the situation of women. It is difficult to make separate health policies for men and women due to failure of separating women from men in national and regional statistics. It is essential to collect sex disaggregated to locate differences in health status. This will enable policy makers to suggest healthy policies to improve health status of different population groups.

Data should be available on the basis of age, sex, gender, women with special vulnerabilities for instance, migrant, refugee and single mothers, women with long term disabilities and coping with chronic diseases. Requirement of the above stated appropriate indicators for measuring

different aspects of health and quality of life should be fulfilled. In many developing countries, the lack of data on women's health reflects in part the very limited nature of the vital registration system, which affects both sexes.

It is also observed that relevant authorities are unable to recognize importance of gender issues and a lack of understanding of the complex social pressures which affects women's health. Similar problems are evident in relation to the identification and measurement of domestic violence. This represents a huge public health problem which has not yet been adequately documented. Gaps in the availability of information in women's lives are now beginning to be filled. The recent development by UNDP of a number of new gender related indicators offers important tools to collect data and achieve the levels of gender equality.

Social determinants of health including gender

Health is a product of the physical and social environment in which we live and act. This environment is always affected by the global and local factors: social, cultural, economic and political. Studies conducted in diverse settings indicate that inequalities in health across populations are largely the consequence of differences in social and economic status and differential access to power and resources.

Substantial evidence exists to indicate that in almost all the societies' women and men have differing roles and responsibilities within the family and in society. Both men and women have unequal access to resources and power. Gender differences are observed in every stratum of society. In the domain of health too gender differences are found.

Differences in the way society values men and women, and accepted norms of male and female behavior, influence risk of developing specific health problems as well as health outcomes. Studies have shown the preference for sons and the undervaluation of daughters in tasks like feeding and health care. This has potentially serious negative health consequences for girls. On the other hand, social expectations about male behavior may expose boys to

a greater risk of accidents, and to the adverse health consequences of smoking and alcohol use.

Coming to the access to health care and health care facilities, both women and men do not have equal access to and control over resources such as money, transport and time. Restrictions on women's physical mobility, common in many parts of India, often make woman dependent on men to accompany her to a health care facility. In many instances biologically determined differences between women and men interact with socially constructed behavior to the disadvantage of women. There are other factors which compound women's vulnerability because of the way society expects women and men to behave.

In a healthy community, all members are able to participate fully within their families, organizations and society. Those who are included, for a variety of reasons, here considering the gender factor, do not have the opportunity for full participation in the economic and social benefits of society. This exclusion has a strong negative impact on individual health and well-being and is seen as a major contributor to chronic diseases, such as heart disease, stroke, and diabetes.

To be truly effective, community-based organizations need to educate themselves about sexual orientation and gender, and they should not only accommodate and respond to those who show interest but also actively seek out others who might have the motivation to become involved. Often an organization can provide greater access and accommodation to others.

Expanding the disciplinary boundaries in health research

Social scientific research is needed if the full range of influences on human health is to be understood. In particular, governments need to support health related research to get a holistic view by anthropologists, sociologists and psychologists. Government can use their findings alongside those of biomedical scientists to develop more comprehensive health promotion

policies. Both quantitative and qualitative approaches should be useful in collecting data on the aspects of gender inequality.

Getting the whole picture

It is essential that the whole range of reproductive and productive activities undertaken by women across the lifespan should be considered. Femaleness can no longer be equated with motherhood and the scope of health research needs to shift accordingly.

Researchers have started documenting the 'black box' of the family. They have started documenting domestic violence, risks associated with domestic work. Women's work outside the home also needs much more attention from both researchers and policy makers. Dual responsibilities handled by women are making them vulnerable to many mental and physical health problems. If these issues are to be taken seriously, occupational health researchers need to develop greater gender sensitivity in their methods of investigation.

(Gender and Medical Education (Reading Material), published by Achutha Menon Centre for Health Science Studies, Trivandrum, Kerala., Ravindran T.K. and Mishra U.S., 2000)

How this Manual came about

This Manual owes its genesis the work of a group of health activists, researchers and women's health advocates who first came together in 1998 as the 'Gender and Social Issues in Reproductive Health Research Initiative.' This informal initiative was supported by the Ford Foundation. Its objective was to identify and address gaps in research on reproductive health in India from a 'gender and social dimensions' perspective. The first phase of this initiative lasted between 1998-2001, and culminated in the production of annotated bibliographies and overview papers on various aspects of sexual and reproductive health: sexuality and sexual health; reproductive health; abortion, HIV/AIDS, the interface between general and reproductive morbidity in women; and sexual and reproductive health services.

The second phase of this initiative began in 2001 December, with dissemination of the findings of the review of literature and a call for research proposals on areas that were under researched. The small grants programme was administered by Achutha Menon Centre for Health Science Studies Trivandrum, Kerala. This programme was also supported by the Ford Foundation.

Several proposals were received for small grants and 11 of these were selected, six from institutions and five from individuals. A methodology workshop was organized for all the grantees in early January 2003 which was attended by grantees and the team of resource persons who had originally assessed the proposals.

The two day methodology workshop was organized with the following objectives:

- To come to a common understanding on gender and gender sensitive research
- To help each researcher clarify the methodology of his / her study through a peer review process within the workshop, freely exchanging ideas and opinions.

The experience of the small grants programme on these gendered research studies proved to be rich. The learnings were distilled for a short course titled 'Gendered Research in Health'. Two of these courses were conducted by WOHTRAC / WSRC in March 2006 and April 2007.

This Manual is the outcome of these short courses. Several persons were historically involved with the 'Gender and Social Issues in Reproductive Health Research Initiative' in these two courses. Members of the Women's Health Training, Research and Advocacy Cell also contributed as faculty. The experience of the two courses is distilled into the session outlines. For several topics, the resource person's input was primarily based on the feedback provided for the participants' group work presentations. Some of the

outcomes of the group exercises and participants' presentations have been retained as illustrations.

How to use this Manual

This manual is intended for persons who are engaged in Health Research, Gender Studies, community based health action, evidence based health advocacy. The manual is designed to give the reader a basic overview of how to mainstream a gender perspective in health research.

This manual can be used by teachers who teach Research Methodology courses, by students who want to do gendered research in health, by health planners and administrators who want to incorporate a gender perspective in the health research that they want to do.

Sections of this manual can be used independently depending upon one's own needs and context. Researchers who are already familiar with quantitative and qualitative research methods may not need to go to these session outlines at all. Instead they might find sessions on gender sensitive indicators more useful. Others might need to understand the concept of gender and would find the first module relevant.

The manual consists of three modules:

Module 1: Introduction to Concepts and Tools in Gender, Health, Rights and Development.

Module 2: Researching Gender and Social Issues in Health.

Module 3: Taking Research Forward: Communication and Advocacy

Module 1: Introduction to Concepts and Tools in Gender, Health, Rights and Development

1. Social construction of gender.

2. Patriarchy in the Indian context.
3. Gender-based inequalities within the context of other social inequalities.
4. Social determinants of health.
5. Rights approach to health.

Module 2: Researching Gender and Social Issues in Health

1. Paradigms of research.
2. Overview of the research process
3. Gender analysis and the research process.
4. Gender analysis framework and specific health conditions
5. Ethics in health research

Module 3: Taking Research Forward: Communication and Advocacy

1. Strategies for communicating research results.
2. Use of research findings for program designing.
3. Nature and types of advocacy, successful advocacy efforts.
4. Evaluate advocacy strategies from a gender and social perspective.

About The Course

Goal

The short course on Gendered Research in Health is aimed to empower researchers and practitioners to carry out gendered research in health.

Objectives

The objectives are to enable the participants to

- Be acquainted with the various concepts used in gender analysis.

- Locate gender-based inequalities within the context of other social inequities.
- Apply gender and rights perspective to epidemiological research approaches.
- Use outcomes of gendered research to develop communication and advocacy strategies.

Profile of Participants

The course is open for men and women familiar with basic concepts of gender and research and working in the area of health. Applicants must be graduates in any discipline, mid career professionals and understand English. Men are encouraged to apply.

The first two courses were attended by persons from diverse disciplines like anthropology, clinical psychology, community health, pediatrics, preventive and social medicine, foods and nutrition, population studies and gerontology, social work, sociology, family and child welfare, history, journalism, organizational development and behavior. The participants were from academic, research institutions as well as NGOs. In addition to people from various states of India, a few participants also came from Bangladesh and Rwanda.

Course Design

The Course consists of three modules

Module 1: Introduction to Concepts and Tools in Gender, Health, Rights and Development

Learning Objectives

1. Define the social construction of gender.
2. Identify the root causes of gender inequity – patriarchy in the Indian context.

3. Locate gender-based inequities within the context of other social inequalities such as class and caste.
4. State the social determinants of health.
5. Work with a gender and rights approach to health.
6. Analyze critically gender and development.
7. Describe the manifestations and material consequences of gender inequality.

Module 2: Researching Gender and Social Issues in Health

Learning objectives

1. Describe the paradigms of research.
2. Describe step by step the research process, beginning with identification of research gaps, developing research questions, selecting appropriate study design, data analysis and report writing.
3. Use the gender analysis tool in the research process.
4. Apply gender analysis framework to specific health conditions.

Module 3: Taking Research Forward: Communication and Advocacy

Learning objectives

1. To learn strategies for communicating research results to relevant audience, formats and media for disseminating research results and writing for journals.
2. Use of research findings for program designing.
3. Describe the nature and types of advocacy necessary and sufficient conditions for successful advocacy efforts.
4. Evaluate advocacy strategies from a gender and social perspective.

Detailed Contents of each Module

Module 1: Introduction to Concepts and Tools in Gender, Health, Rights and Development.

Session 1: What is Gender?

Session 2: Patriarchy

Session 3: Social Construction of Masculinity and Femininity

Session 4: Locating Gender Inequalities within Class and Caste

Session 5: Health as a Development and Gender Issue

Session 6: Sexuality and Violence

Session 7: What are Rights?

Session 8: Applying the Rights Approach to Health

Session 9: Review of Module 1

Module 2: Researching Gender and Social Issues in Health.

Session 10: Research Process - Step by Step

Session 11: From Research Ideas to Research Questions

Session 12: Literature Review

Session 13: Paradigms of Research

Session 14: Overview to Qualitative Methods

Session 15: Secondary Data: A useful source in research

Session 16: Gendered Research

Session 17: Gender Indicators

Session 18: Gendered Study Designs

Session 19: Developing Gender Sensitive Data Collection Tools

Session 20: Analyzing Qualitative Data

Session 21: Managing Data and Writing Reports

Session 22: Applying Gender Research Methods: Researching Men

Session 23: Ethical Issues in conducting a Research Study

Session 24: Review of Module 2

Module 3: Taking Research Forward: Communication and Advocacy

Session 25: Communicating Research

Session 26: Writing for Journals: A View from the Editor's Desk

Session 27: From Research to Program Design

Session 28: From Research to Advocacy

Session 29: Advocacy Tools and Strategies

Session 30: Review of Module 3

Session 31: Evaluation of the course

Time Table

Day 1 -- Module 1	Time
Welcome and Introduction, Objectives and Design, Administrative matters	9:30 am – 10:30 am
Tea Break	10:30 am – 11:00 am
Session 1: What is Gender?	11:00 am -12:30 pm
Session 2: Patriarchy	12:30 pm – 1:30 pm
Lunch Break	1:30 pm – 2:30 pm
Session 3: Social Construction of Masculinity and Femininity	2:30 pm – 4:00 pm
Session 4: Gender Inequalities, Power and Control	4:00 pm – 5:30 pm
Day 2 – Module 1	**Time**
Feedback from Participants about Day 1	9:00 am – 9:30 am
Session 5: Health as a Development and Gender Issue	9:30 am – 12:30 pm
Lunch Break	12:30 pm – 1:30 pm
Session 6: Sexuality and Violence	1:30 pm – 3:00 pm
Session 7: What are Rights?	3:00 pm – 4:30 pm
Session 8: Applying the Rights' Approach to Health	4:30 pm – 5:30 pm
Day 3 – Module 1 and Module 2	**Time**
Feedback from Participants about Day 2	9:00 am – 9:30 am
Session 8: Applying the Rights' Approach to Health	9:30 am – 10:00 am
Session 9: Revision of Module 1	10:00 am – 11:30 am
Module 2 **Session 10**: Research Process: Step by Step	11:30 am – 1:30 pm
Lunch Break	1:30 pm – 2:30 pm
Session 11: From Research Ideas to Research Questions	2:30 pm –4:00 pm
Session 12: Literature Review	4:00 pm – 5:30 pm

Day 4 – Module 2	Time
Feedback from Participants about Day 3	9:00 am – 9:30 am
Session 13: Theme: Paradigms of Research	9:30 am – 1:30 pm
Lunch Break	1:30 pm – 2:30 pm
Session 14: Overview of Qualitative Methods	2:30 pm – 4:00 pm
Session 15: Secondary Data: A Useful Source in Research	4:00 pm – 5:30 pm
Day 5 – Module 2	**Time**
Feedback from Participants about Day 4	9:00 am – 9:30 am
Session 16: Gendered Research	9:30 am - 11: 30 am
Session 17: Gendered Indicators	11:30 am – 1:00 pm
Lunch Break	1:00 pm – 2:00 pm
Session 18: Gendered Study Designs	2:00 pm – 3:30 pm
Session 19: Developing Gender Sensitive Data Collection Tools	3:30 pm – 5:30 pm
Day 6 – Module 2	**Time**
Feedback from Participants about Day 5	9:00 am - 9:30 am
Session 19: Developing Gender Sensitive Data Collection Tools….continue	9:30 am – 10:30 am
Session 20: Analyzing Qualitative Data	10:30 am – 11:30 am
Session 21: Managing data, Writing Reports	11:30 am – 1:30 pm
Lunch Break	1:30 pm – 2:30 pm
Session 21: Managing Data continued…	2:30 pm – 3:30 pm
Session 22: Applying Gender Research Methods	3:30 pm – 5:30 pm
Day 7 – Module 2 and Module 3	**Time**
Feedback from Participants about Day 6	9:00 am – 9:30 am
Session 22: Applying Gender Research Methods continued…	9:30 am – 10:30 am
Session 23: Ethical Issues in Conducting a Research Study	10:30 am – 12:00 noon
Session 24: Review of Module 2	12:00 noon – 1:00 pm
Lunch Break	1:00 pm – 2:00 pm

Day 8 – Module 3	Time
Feedback from Participants about Day 7	9:00 am – 9:30 am
Session 25: Communicating Research	9:30 am – 10:30 am
Session 26: Writing for Journals: A View from the Editor's Desk	10:30 am – 1:30 pm
Lunch Break	1:30 pm – 2:30 pm
Session 27: From Research to Programme Design	2:30 pm – 4:30 pm
Day 9 – Module 3	**Time**
Feedback from participants about Day 8	9:00 am – 9:30 am
Session 28: From Research to Advocacy continued…	9:30 am – 10:30 am
Session 29: Advocacy Tools and Strategies	10:30 am – 12:00 noon
Session 30: Review of Module 3	12:00 am – 1:00 pm
Lunch Break	1:00 pm - 2:00 pm
Session 31: Evaluation of Course, Future Plans, Closure etc.	2:00 pm – 3:30 pm

SECTION II

Session Outlines

Module 1

Introduction to Concepts and Tools in Gender, Health, Rights and Development

Learning Objectives

1. Define the social construction of gender (including masculinity).
2. Identify the root causes of gender inequality – patriarchy in the Indian context.
3. Locate gender-based inequalities within the context of other social inequalities such as class and caste.
4. State the social determinants of health.
5. Work with a gender and rights approach to health.
6. Analyze critically gender and development.
7. Describe the manifestations and material consequences of gender inequality.

Session 1: What is Gender?

Learning Objectives

Participants will be able to:

- Differentiate between sex and gender
- Describe how gender operates as a system
- Define terms like: Gender norms, Sexual division of labor, Gender roles, Access to and control over resources

Methodology: 1. Role Play and discussion 2. Quiz 3. Presentation

Time: 90 minutes

Activities

1. Role Play

Participants are divided into four groups on the following situation given to them:

Twins (a boy and a girl, named Jack and Jill) are born in a family. Through the role play, show what happens in their family, neighbourhood, educational institutions through each life stage. Depict in what ways their personalities will be constructed throughout the life cycle. What will be the constructions and manifestations of gender roles and behaviors for the boy and the girl? Group 1 will show Birth of Jack and Jill till 5 years. Group 2 will show Jack and Jill ages 6 to 16. Group 3 will show Jack and Jill from 17 to 30 years. Group 4 will show jack and Jill at the age of 70 years. Each role play should not be more than 7 minutes.

After 15 minutes of preparation time, each group presents their role play. The discussion after each role-play picks up the differences in which family and society treats girls and boys. The facilitator points out the process of

socialization and social control. The institutional nature of how gender operates is also pointed out – for example, within the educational system, in the market, in media as well as in the family.

The resource person can point out that the presentations made by all five groups shows a pattern in which it is clearly visible how from the very beginning and at every stage of life, girls and women are discriminated against. Discrimination occurs, even before birth in the form of pre-conception sex selection and selective abortion of female fetuses after sex determination. At every stage of life there is preferential treatment given to boys and men. The manifestation of discrimination against girls and women varies according to their context and class.

2. Quiz

The role-play and discussion is followed by a quiz on sex and gender. A list of statements is given to the participants and they are asked to identify whether the statements were related to gender or to biological sex.

Following are the statements.

Box 1

Biological Sex vs. Gender: Participants' views			
Statements	**Biological sex**	**Gender**	**Could be both?**
Women are better at caring for children than men			
Men have lots of body hair.			
Men wanted to learn nursing, but was not allowed.			
Men impregnate women.			
Women neglect their own health needs.			
Women breastfeed babies.			
Male doctors do postmortem.			
Men's voices break at puberty.			
Boss makes sexual advances to a young married woman colleague.			
Women menstruate and also undergo menopause.			
Men are soldiers, because they are brave can use weapons to fight.			
Women are more at risk from RTIs /STDs.			
Men are better leaders than women.			
Men tend to bald faster than women.			
Women are better parents than men.			
Body hair is okay for men, but women have to remove it.			

The responses to each statement are discussed and participants are helped to gain clarity about the differences between gender and biological sex.

Gender and Sex Differences

- *Gender identifies the socially constructed characteristics that have come to define male and female ways of being and behavior within specific historical and cultural symbols, norms, institutional structures and internalized self-images, which through a process of social construction define what is meant by "masculine" and "feminine".*

- *Gender role socialization also prescribes what are appropriate masculine and feminine sexual roles and behaviors. In many cultures, female resistance, male aggression, and mutual antagonism in the sex act is viewed as the norm.*

- *People's understanding of sexuality is culturally conditioned and changes over time. The relationships between the constructs of gender and sexuality are strong, but many theorists believe that they are connected but not identical systems of meaning.*

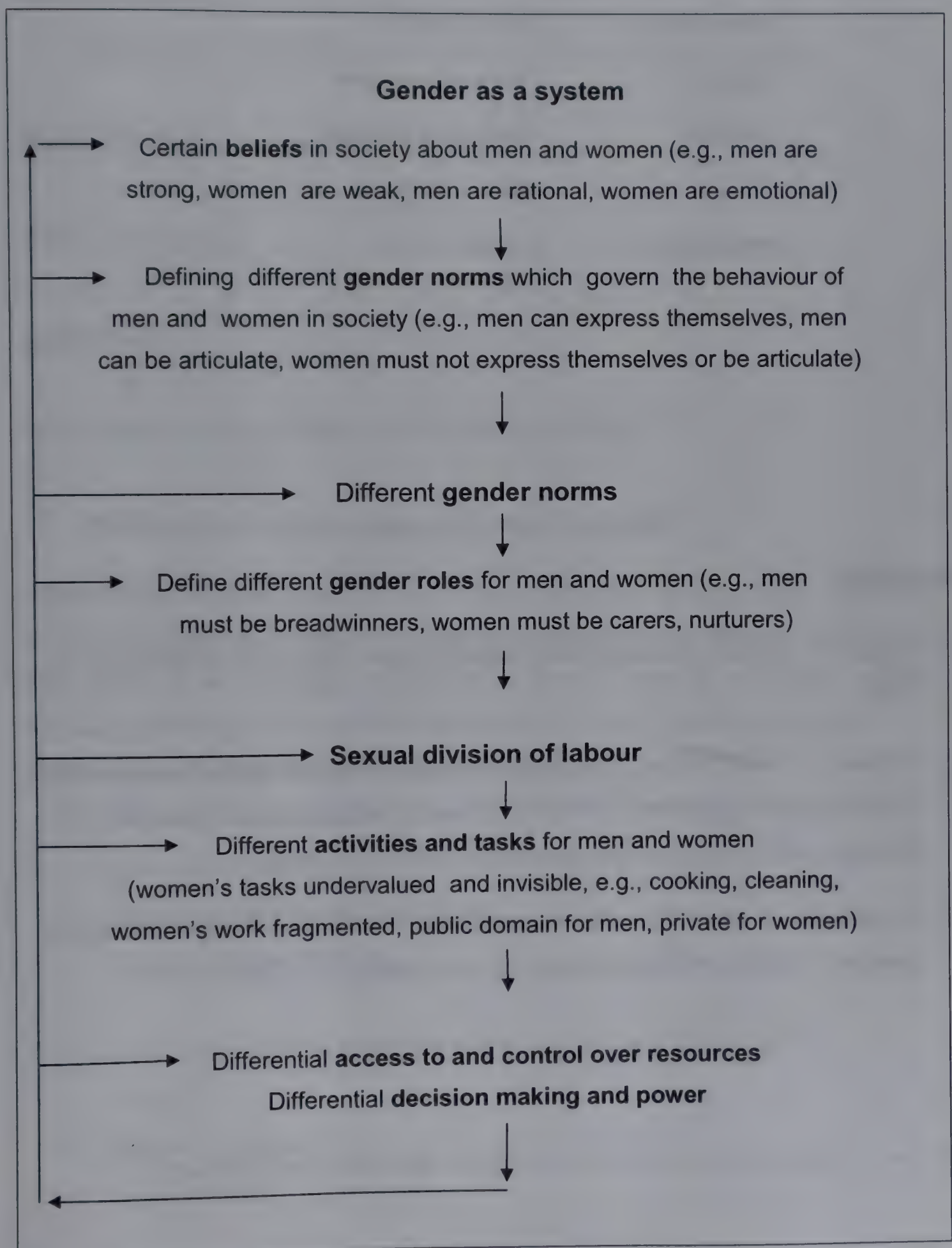
- *Gender is a context-specific concept: gender relations vary according to ethnic group, class, culture, and so on. This underlines the need to incorporate diversity when we analyze gender.*

- *Gender relations have changed over time, because they are nurtured by factors that change over time. This means that current gender relations are not necessarily fixed, and can be modified through interventions.*

- *Gender relationships are personal as well as political. Personal, because the gender roles that we have taken on define who we are, what we do and how we think of ourselves. Political, because gender roles and norms are maintained and promoted by social institutions. Challenging these means challenging the way society is currently established.*

3. Presentation on 'Gender as a System'

Through this presentation the facilitator defines terms like Gender norms, Sexual Division of labour, Gender Roles, Access to and Control over Resources.



Characteristics of gender

Relational	:	*Socially Constructed*
Hierarchical	:	*Power Relations*
Change	:	*Changes over time*
Context	:	*Varies with ethnicity, class, culture, etc.*
Institutional	:	*Systematic and Organized*

Readings

1. Bhasin, K. (2000). Understanding Gender. New Delhi: Kali for Women, pp. 1-86

2. Reeves, H. and Baden, S. (2000, February) Gender and Development: Concepts and Definitions. BRIDGE (development- gender), Report No. 55, Brighton, UK: Institute of Development Studies, pp. 1-37

3. Whitehead, A. April 1979. *'Some preliminary notes on the subordination of women'.* Institute of Development Studies Bulletin. 10 (3) pp. 10-13.

Based on the session developed by Renu Khanna and N.Rajaram

Session 2: Patriarchy

Learning Objectives

The participants will be enabled to:

- Identify the root causes of gender inequality
- Describe patriarchy in the Indian context
- Describe the manifestations of patriarchy in daily life and medicine

Methodology: Lecture and Discussion

Time: 60 minutes

Activities

The facilitator's lecture covered the following issues:

- **Patriarchy as a root cause of gender inequality**

Patriarchy: a term used in several ways to describe the structures and social forms that make up a system of male dominance and female subordination. It also refers to an ideology, originating in men's power to exchange women between kinship groups, and institutionalized as the power of the father.
Patriarchy is a **system** that exercises control over:

- Women's labor power
- Women's sexuality
- Women's mobility and resources
- Women's reproductively

There are social institutions which enable men to control over women-

- Family
- Religion / ideology
- Legal system

- Economic system and economic institutions
- Political systems and institutions
- Media

Patriarchy in the Indian context

- In India, motherhood is glorified in all customs and traditions and it finds expression in most folksongs. However, motherhood in an unmarried woman is unacceptable in society, because the child has to bear the name of someone who belongs to the same or a specific caste or class, or religious community. Similarly, being the mother of daughters and a woman's inability to bear sons are stigmatized. Motherhood is equated with being the mother of a son.
- The manifestation of patriarchy in India cannot be discussed without considering caste and class. For instance, there is greater control over upper caste women in terms of mobility and sexuality, whereas women of the low castes have greater mobility, because it would be impossible for society to function if low caste women were also confined to the four walls of their homes.
- The ideology of wifely fidelity and chastity (pativrata), practices such as sati, prescription of an austere life for widows, ban on their remarriage, were all aimed at controlling the sexuality of upper caste women.
- The form of patriarchy in India is described as brahminical patriarchy. According to Uma Chakravarti[1] it is a complex relationship between caste, class and gender. The brahminical social order was based on caste and gender hierarchies. Women were valued for their contribution as producers as well as their ability to reproduce. Therefore we see the worship of female power. With the advent of the Aryans, who conquered vast tracts of land and subjugated the local inhabitants, the caste and class stratification of society evolved. Gradually, as agriculture replaced the pastoral economy and the labor of low caste men and women from

[1] Uma Chakravarti, "Conceptualising Brahmanical Patriarchy in Early India: Gender, Caste, Class, and State," Economic and Political Weekly, April 3, 1993.

the subjugated clans became available, the participation of Aryan women in the labor force discontinued, and they retreated into their households

- In every culture and society there are many sayings about the woman. In Gujarati society one such adage is common. A Gujarati adage compares a woman's character with a pot of clay, implying that both tend to break easily.

Manifestations of patriarchy in medicine

- Predominance of male bodies can be observed in illustrations on human anatomy. Female bodies are shown only on the topic of reproduction.

- Certain courses of study in medicine are pursued more by men than women. Male students usually opt for specializations like surgery or orthopedics while women opt for subjects that are less demanding on their time, or they study subjects, which are suitable for jobs that do not require emergency duties, subjects such as ENT or Anesthesia.

Readings

1. Bhasin, K. (1993).What is Patriarchy? New Delhi: Kali for Women, pp. 1-41

2. Ehrenreich, B. (1974). Gender and Objectivity in Medicine. International Journal of Health Services, pp.617-623

3. Iyengar, Kr. '*Review of Medical textbooks of Obsetrics and Gynaecology*'. ARTH, Udaipur.

Based on session developed by Trupti Shah and Janhavi Andharia.

Session 3: Social Construction of Masculinity and Femininity

Learning Objectives

The participants will be able to describe

- The concept of masculinity and masculinities.
- Social construction of masculinity and femininity and how this contributes to maintaining gender-based inequalities.

Methodology: 1 Participatory exercise 2. Presentation and discussion

Time: 90 minutes

Activities

1. **Participatory exercise:** Free Listing of words associated with the terms *masculinity* and *femininity*

Man	Woman
Strong	Emotional
Dominating	Caring
Aggressive	Long hair
Sports	Teacher
Macho	**Independent**
Protector	Provider
Head of the family	Preparer
Short hair	House wife
Irresponsible	Adjusting
Father	**Jealous**
Beard	Balanced
Pants/ Shirts	Mother
	Saris
	Manager
	Sacrificing
	Tolerance
	Exhibiting

2. Presentation on masculinities

This presentation is aimed to enable participants to

- Understand the social construction of masculinities
- Understand how construction of masculinities at times disadvantages men and boys.
- Identify ways in which challenging dominant construction of masculinities can result in positive gains for women and girls, as well as men and boys.

The presentation highlights the following:

- The term masculinity may be defined as a way to explain men's behaviour, power and responsibilities in relation to women, and to each other.

- There are three explanations: Biological essentialism, cultural or social construction, and power discourse.

  Biological essentialism: Men and women are different due to their biology and hormones.

  Social constructionism: Men and women are socialized differently and hence they are different.

  Power discourse: Anything powerful is considered masculine and powerless is considered feminine

- Masculinity is shaped in relation to:

  A general symbolization of difference, i.e. the opposition of femininity to masculinity, and between different masculinities.

  An overall structure of power: The subordination of women to men, and some men to others.

Power: The dominant construction and power discourse of masculinities places women in a powerless situation more often than men. At times it places men also in a disadvantaged and powerless position.

There are different institutions that shape the construction of masculinities: family, community, work place, religion, school, government. There is no one

way of being a man, it varies with age, race, religion, caste, age, relation, position, as well as contexts at any given time. Hence the term 'masculinities' rather than 'masculinity' is preferred

Given that men are disadvantaged there is scope for working with men and women in changing dominant construction of masculinities.

Key Points

1. Similar to gender and patriarchy the concept of masculinity and femininity is also socially constructed.
2. The traits/attributes which are termed as masculine or feminine are not only due to biology but are also culturally and socially loaded.
3. Power again plays a central role in masculinities due to which women and men (who are considered deviant) are put into disadvantaged and powerless position. Although the situations are different for men and women.
4. The definition of gender is changing and the term masculinities is preferred over masculinity.
5. The construction of masculinity and femininity is closely linked, interwoven and influenced by different clothing of men and women (mainly sari for women and pants for men which restrict mobility of women and make them appear modest and feminine) and exhibiting the marital status of women by *sindoor* and *mangalsutra*, which signifies their chastity and identity dependent on men.
6. Different sexual identities should be respected and find place in research, NGO interacting, government policies, laws, etc.
7. Some thing to be careful about is that 'protectionism' is not promoted as the desired form of 'sensitive masculinity'. Men should not swing to the other extreme and start protecting women; they need to balance the respect for women's individuality and strength with caring for them.

Readings

1. Do men matter? New horizons in gender and development. Pillow talk: Changing men's behaviour. Targeting men for a change. Why men? Why now? Do weak states undermine masculinities? Men against marital violence: 9 Nicaraguan Campaign sites for Sore Eyes: Online sources on men and masculinities. Id 21 insights, December 200. No. 35. – id 21 website.

2. Kulkarni, M. 2001, May *'Reconstructing Indian masculinities'*. Gentleman pp. 1-3.Grieg, A. Kimmel, M., and Lang, J. (2000, May). Men, Masculinities and Development: Broadening Work towards Gender Equality. Monograph # 10. UNDP/ GIDP

3. Fausto- Sterling, A. (1997). How to Build a Man. In R.N.Lancaster and M. di Leonardo (Eds.), The Gender/ Sexuality Reader. New York: Routledge, pp. 244-248

4. Martin, E. *'The woman in the body'. A cultural analysis of reproduction*. Beacon Press, Boston.

Based on the session developed by Renu Khanna and N.Rajaram

Session 4: Gender Inequalities, Power and Control

Learning Objectives

The participants will be able to:

- *Describe the basis of discrimination*
- *Locate gender-based inequalities within the context of other social inequalities such as class and caste.*
- *Understand the concepts of power and control*

Methodology: 1. Participatory exercise – "Power Walk" 2. Discussion

Time: 90 minutes

Activity

Power walk

1. Inform participants that they will now play a game and take them to a place which is roughly 100 feet long and 50 feet wide.

Here distribute the individual slips of their identities to each participant (Annexure 1). Inform participants that for the duration of the game they will assume the identity of the person written on their individual role slip. Some will have identities of women and some of men.

2. Line up participants in the middle (50 feet mark) of the field/hall. Inform them that they must take steps forwards or backwards depending upon what they think the person mentioned in the slip will be able to do or not do in response to each of the statements that the facilitator reads out. The objective of the game is to reach the end of the field (100 feet mark) first.

3. Now start reading out one statement at a time from the instruction sheet - giving the participants enough time to step forward or backward.(Annexure 2)

4. After all the statements have been read out; inform the group who the winners are depending upon who is closest to the 100 feet mark.

5. Now ask the persons who are closest to the finish line (the winners) to reveal their identities as mentioned on the slips and say how they feel. Then ask the others who are farthest away from the finish line (the losers) to reveal their identities and ask how they feel. Put this on the board as shown.

Winner's - Feelings	Identity	Loser's – Feelings	Identity

6. Ask the participants pairs (male – female) about where the other member of the pair is – where are they placed with respect to each other.

(Game takes around 45 minutes)

Discussion (45 minutes)

1. Why did the participants get distributed in this was even though they had started at the same place in the game?

2. What were the various bases of differences in the game? How did these differences affect each individual player? (Write on the board various bases of difference)

3. Explain how each individual may be at an advantage on one basis but at a disadvantage on another basis – and how advantages along a particular basis – caste, class, religion, age etc is also a source of power.

4. Establish the basic value of equality. (See Key points)

5. Facilitator concludes by stating that individuals are discriminated against on the basis of their class, caste, age, sex, educational levels, and physical abilities and so on. Power operates to keep discrimination in place.

Understanding 'power'

a) **Power over** – (either/or) power in decision making processes in the family (man over his wife, parents over their children, mother-in-law over daughter-in-law), in the community, village, and also at the level of the State. One party or a person having power over another person.

b) **Power to** – (individual) power as ability to effect change: it can happen when the person with power comes down to the level of the powerless and understands their situation. The powerful can choose to involve the powerless and affect change in their social situation and thus "give them" power.

c) **Power with** – (collective) power as unity and common causes. The situation can change when individuals are able to speak up and unite to form a collective/team or solidarity group. When women are able speak up, their husbands feel they are losing control and may resort to physical violence.

d) **Power within** – (spiritual/inner) power as respect for difference. This process will create transformation within oneself through internal realisation.

Factors or situations, such as authority, position, and education gave the feeling of power or being powerful.

Key points

- Gender is one basis of discrimination. The others are caste, class etc. None of these operate independently of the other. They are interlinked. Each of these could be a source of power in different situations.

- There is social institutions (political, cultural, religious, social) operating in society that further discriminates. For instance, availability of educational opportunities for adivasi women is not the same as an urban man or woman. Similarly, in the case of health, employment opportunities, and adoption laws.

- Discrimination is also reinforced by cultural and religious practices, such as male preference, death rites and restrictions on women after marriage.

- The Indian Constitution gives every citizen of this country equal rights. However, if this is to materialize, we would have to change all social institutions that discriminate.

- If we want to bring about equality among all men and women, we would have to put into place mechanisms that make sure women are able to operate in society without restrictions to their mobility, without questions about safety, or abuse. We would also have to challenge the institutions of caste and class.

Annexure 1 – Identities that the Participants have to take

- Male doctor
- Woman doctor
- Man sarpanch
- Woman sarpanch
- Poor rural woman
- Poor rural man
- Illiterate dalit woman
- Illiterate dalit man
- Adivasi woman
- Adivasi man
- Single woman
- Single man
- Christian woman
- Christian man
- Muslim woman
- Muslim man
- Illiterate wife of money lender
- Money lender
- Mother of three daughters
- Father of three daughters
- Undergraduate female student
- Undergraduate male student
- Female judge
- Male judge

Annexure 2 - Instructions for the game

1. If you have studied up to class VII, please take two steps forward, if you have not then take two steps back.
2. You need Rs.2000 for some personal work, and you do not want to ask your partner for it. If you can arrange a loan from a bank take one step forward. If you cannot take one step backward.
3. If your know how to work on a computer take one step forward, otherwise take one step backward.
4. There is a rumour that there is rioting in the city. You are stuck out of home. If you feel frightened in going home take one step backward, if you do not, take one step forward.
5. You do not want a child. If you can convince your partner to use a contraceptive take two steps forward, otherwise take two steps back.
6. There is a party/cultural programme at a friend's house tomorrow night. If you can go on your own, take one step forward otherwise take one step back.
7. If you have ever raised your hand on your partner take two steps forward, otherwise take two steps back.

8. If you read the newspaper every day take one step forward, otherwise take one step back.
9. Two men are bullying a little girl on the roadside; you see it and do not like it. If you can go and stop them take one step forward otherwise take one step back.
10. You like singing, if you were able to take classes to fulfill your ambition, take one step forward otherwise take one step back.
11. You do not like washing dishes, there is a pile of dishes to be washed. If you do not need to wash these dishes take one step forward otherwise take one step back.
12. Your father died recently. If you were allowed to perform the last rites take two steps forward, otherwise take two steps back.
13. You had to go out of town/village on some work and the work has taken longer than you thought. If you think that you will get permission to stay out of the house at night take one step forward otherwise take one step back.
14. If you ride a cycle/or any vehicle to work, or for daily errands take one step forward, if you do not, then take one step backwards.
15. Nearby, there is a new factory to manufacture parts for automobiles. They are hiring personnel. If you think you can get a job, take one step forward, if not take one step backward.
16. You and your partner have decided you want to parent a child. You would like to adopt a baby girl. If you think this is possible take one step forward. If not, take one step back.
17. Your parents have died. If you think you will get a share in their property take a step forward, if not take one step back.

Readings

1. Liddle, J. and Joshi, R. (1998). Daughters of Independence: Gender, Caste and Class in India. (Chapters 6-10), pp. 49-83.

2. Bhopal, K. (2000). *Gender, 'Race' and Power in the Research Process: South Asian Women in East London (Chapter 5).* In C. Truman, C., D. Mertens, and B. Humphries (Eds.), Research and Inequality. USA and UK: UCL Press, pp. 67-79.

Based on the session developed by Renu Khanna and N.Rajaram.

Session 5: Health as a Development and Gender Issue

Learning Objectives

The participants will be able to:

- Differentiate between the biomedical and socio cultural approaches to health.
- Identify the determinants of health.
- Identify the gender dimensions of health.
- State the social determinants of health, analyze health from a development and gender perspective.
- Describe material consequences of gender inequality with respect to the household, community, market and state.

Methodology: 1. Analysis of case studies, 2. Presentations of readings by participants

Time: 180 minutes

Activity

Analysis of case studies

1. Group Exercise: Each group is given one case study: Lakshmi or Sheela. Participants have to answer the questions for each case study.
2. Presentations and discussions in the plenary
3. Presentation by facilitator to highlight the following
    - Health is not just absence of disease or physical symptoms; it is a composite of physical, mental and social
    - There is difference between bio medical and socio cultural approaches to health.

- Health is a socially created reality, several micro and macro factors affect the health status of individuals and groups as shown in the table below.

Multilevel framework

Individual	Household	Community	National	International
Biological or genetic; age; parity; birth order; education; employment; decision-making power; marital status	The social and economic status of the household within the community; the household's access to resources	Level of development; rural or urban; stratified or homogenous; having health resources or not; inheritance norms, norms for place of residence after marriage	Size of the country; population; level of development; type of governance; structure of the health system; extent to which dependent on the global market; nature of health policies and contours of health sector reform packages	Global economic scenario and dominant economic ideologies; balance of power between various geo-political forces; health sector reform; international human rights regime

- Differences in people's health status including gender differences arise not only from biological differences but also from differentials in social and economic status.

- Social determinants of illness can be confronted and modified by policy interventions.
- Social causes of ill health are related to issues of social justice and equity. These can be changed if there is political will.

Activity

Presentation of readings

1. Group Exercise: Participants are divided into groups and each group is assigned one of the following readings on gender and health, as homework:

   Pendse, V. (2001). ***Maternal deaths in an Indian Hospital: A decade of no change?*** Reproductive Health Matters, Special Supplement on Safe Motherhood Initiatives, Critical Issues, pp. 119-126.

   Krieger, N. (2003). ***Genders, sexes, and health: What are the connections — and why does it matter?*** International Journal of Epidemiology, 32, pp. 652-657.

   Doyal, L. (1995). ***In Sickness and in Health***. In What makes women sick: Gender and political economy of health. New Brunswick, NJ: Rutgers University Press.

   Verheij, R. A. (1996). ***Explaining Urban-Rural Variations in Health: A Review of Interactions between Individual and Environment.*** Social Science and Medicine, 42(6), pp. 923-935.

2. Each participant has to first read the paper individually as homework. The next day the groups are given one hour to prepare presentations as follows:
   - A brief introduction to the paper: title, author(s), whether it is a research study, a review article, or chapters from a book
   - Outline of the main thesis or argument in no more than five or six lines: what is the paper about? What is it telling us about how social class, race/ethnicity or gender influences health status?
   - Description of how the article builds the arguments towards the main thesis.

- Conclusion: the group's reaction to the paper. Did the group find the paper useful? In what ways? Are there some points they do not quite agree with? Why?

The groups were instructed to focus only on the main points in the paper and if necessary illustrate the arguments, with not more than three tables or graphs.

3. Group presentations on each paper. Responses by other groups following each presentation.

4. After each group makes their presentation, the facilitator summarizes the Key Messages as follows

- Health is not purely a biological issue but there are important social determinants of health. Health is a socially constructed reality, a product of the physical and social environment in which we live and act.
- Many factors at many levels (starting from individual to household to community to national to international) affect health of an individual. A nuanced analysis is required of all these factors.
- Differences in people's health status including gender differences arise not only from biological differences but also from differentials in social and economic status
- Social determinants of illness can be confronted and modified by policy interventions
- Social causes of ill health are related to issues of social justice and equity. These can be changed if there is political will.
- Health care providers generally address only physical problems, and the underlying factors remain unnoticed.
- A public health approach recognizes underlying factors. A public health approach will take into account that the woman must have adequate nutrition, what is going on in her family, her level of awareness and that of her family's. And so on. A public health approach recognizes that only

giving iron tablets or micronutrients is a waste if the public distribution system does not facilitate access to food for poor women.

- Health is a subjective experience. The researcher needs to take into account the experiences of people and respect their views. The idioms of the community and the perspective of community members need to be understood while designing a health programme.
- Development is a multidimensional concept and economic development is just one aspect of it. Social sector indicators - access to health and education, respect for human rights, political rights in terms of freedom of expression, and so on are also important aspects of 'development'. Increasing GDP and economic growth of the nation do not really make the nation developed when a majority of the population is below poverty line, and there are gross gender disparities. It is interesting to note that Bhutan measures its growth by happiness, adequate food for all, shelter, number of schools, health, employment, democracy, freedom of expression and satisfaction of people

Readings

1. Verheij, R.A. (1996). Explaining Urban-Rural Variations in Health: A Review of Interactions between Individual and Environment. Social Science and Medicine. 42 (6), pp. 923-935.

2. Batliwala, S(1994). The meaning of Women's Empowerment: New Concepts from Action. In G. Sen, A, Germain, and L, Chen (Eds.0, Population Policies reconsidered- Health Empowerment and Rights. Harvard Series on Population and International Health, Cambridge, Massachusetts.

3. Pendse, V. (2001). Maternal Deaths in an Indian Hospital: A decade of no change? Reproductive Health Matters. Special Supplement on Safe Motherhood Initiatives, Critical issues, pp. 119-126.

Based on the session developed by Jahnavi Andharia and Renu Khanna.

Case Studies

Case study 1: Sheela

Sheela belongs to Dhikiagaon, which is about 20 kms from the district headquarters (Sonitpur), in Assam. She is 19 years old and works as an agricultural wage labourer. Sheela grew up in another village. She was the first of the four surviving children – three girls and a boy. Her father lived with another woman. The family suffered a lot because of this. Sheela's mother had to go out and earn. Sheela had to stop going to school after class 1. She had to look after her brothers and sisters and do the household chores so that her mother could go and work outside. When she was 10 years old she started working as an agricultural labourer.

When Sheela was only 15, she was married off to Mohun. Mohun was 24, and was also an agricultural labourer and hardly had any property. Sheela did not conceive for two years. Her mother-in-law got angry and started scolding her.

She became pregnant when she was 17 years old. Her first pregnancy was very difficult. Her arms and legs were swollen and something would cloud her vision. She would also vomit everything she would eat day in and day out.

But she never went to see a doctor because people said that this is how it is when one is pregnant. A baby girl was born to her. Her delivery took place at home, and the elderly women from the village attended it, as the doctor was miles away and there were no buses.

Within a year, a second baby was born. But he died in a few days: vomited once in the morning, was taken to the hospital immediately but died. The third was a daughter and she died a few hours after birth. Some said that the baby had a weak heart while others said that Sheela was very weak. The baby was very small and skin and bones. She felt very sad and was depressed.

After her third delivery, Sheela started having foul smelling white discharge frequently. She did not give much attention to it, and thought it was because of her weakness. Her fourth baby was born recently and is a boy. She wanted to have a family planning operation, but the family said that one more boy was required. However Sheela feels that she is too weak and will not be able to survive another childbirth.

1. What symptoms did Sheela present with?
2. How would a typical health care provider address these problems?
3. What are the causes of health problems? Categorize the causes into (a) those related to gender (b) others?

Case study 2: Lakshmi

Lakshmi belongs to a village in central Tamil Nadu, located about 15 km from the district headquarters. She is 27 years old, an agricultural wage labourer and belongs to the Scheduled Castes.

Lakshmi grew up in another village. She was the first of four surviving children – three girls and a boy. Her father had another woman. The family suffered a lot because of this. Lakshmi's mother had to go out to earn. Lakshmi was stopped from attending school after Class I. She would graze cattle and earn money, and when she was about 10, started working as an agricultural labourer.

When Lakshmi was only 14, she was married off to her uncle's son, Ramu, because there would be no dowry involved. Ramu was 25 and was also an agricultural wage labourer without any property.

When they got married, Ramu told Lakshmi that times had changed, and that they should have only two children. If they had a boy and a girl, she should have an operation. But somehow, Lakshmi never conceived for two years. Her mother-in-law started abusing her.

She conceived when she was 17. Her first pregnancy was very difficult. Her arms and legs and even her face were swollen, and something would cloud her vision. She would also vomit everything she ate, day after day. But she never went to see a doctor. People said this is how it is when one is pregnant. A baby girl was born to her. After the delivery, in a government hospital, all these problems went away.

The second baby was also born in a hospital. But he died in a few days: vomited once in the morning, was taken to hospital immediately but died. The third was a daughter, and she died a few hours after birth. Some doctors said the baby had a heart problem while another said that Lakshmi was very weak. Some others said that it was because she had married a close relative. But the baby was very small and only skin and bone. Lakshmi felt heart-broken.

After her third delivery, Lakshmi started having foul-smelling white discharge frequently. She did not do anything about, telling herself that this must be because of weakness. Lakshmi started a *vrat*, fasting once a week for a healthy birth the next time. Her fourth baby was born recently, and is a boy. Lakshmi wanted to have a family planning operation, and so did Ramu. But the doctors said that she was too weak, and sent her home. They asked her to come back after her health improved.

Lakshmi is now desperate. She does not want to conceive immediately and wanted to make sure that her son survives and grows into a healthy child. But knowing her husband she thinks abstinence is not feasible. She is afraid that if she refuses, he will take another woman just like Lakshmi's father did.

1. *What symptoms did Laxmi present with?*
2. *How would a typical health care provider address these problems?*
3. *What are the causes of health problems? Categorize the causes into (a) those related to gender (b) others?*

Session 6: Sexuality and Violence

Learning Objectives

The participants will be able to:

- Describe the concept of sexuality
- Describe violence against women in its various dimensions
- Analyze the interlinkages of both with gender and health

Methodology: Interactive lecture with presentations

Time: 90 minutes

Activity

1. Construction of male and female sexuality

Ask participants what words come to their minds when they think of sexuality of men and women.

Participants' Responses

Male	**Female**
Dominant	Submissive
Freedom of expression	Shy
Aggressive	Hesitant
Force	Shame
Pleasure	Guilt
More preferences	Honour
Identity	Reproduction
Right	Fertility
Powerful	Duty
Polygamous	Beauty
Active	**Passive**
Desire	Rape
	Fear
	Beauty

The facilitator points out that male and female sexuality is constructed as described above. What affects would this have on health of individuals?

- Wives cannot say 'no' to sex (duty), thereby subjecting themselves to unwanted pregnancies, painful sex
- Men are supposed to be adventurous, risk-taking, experienced. They therefore have multiple sexual partners; have unsafe, unprotected sex leading to infections.

2. Facilitator presents some definitions and linkages of Sexuality and Health

Sexuality

Sexuality refers to culture-bound conventions, roles, and behaviours involving expressions of sexual desire, power and diverse emotions, mediated by gender and other aspects of social position (e.g., class, race/ethnicity, etc.). Distinct components of sexuality include: sexual identity, sexual behaviour and sexual desire.

Sexual identities

Contemporary 'Western' categories by which people self-identify or can be labeled include: heterosexual, homosexual, lesbian, gay, and bisexual, 'queer', and transgender, transsexual.

Heterosexism, the type of discrimination related to sexuality, constitutes one form of abrogation of sexual rights and refers to Institutional and Interpersonal practices whereby heterosexuals accrue privileges (e.g., legal right to marry and to have sexual partners of the 'other' sex) and discriminate against people who have or desire same-sex sexual partners, and justify these practices via ideologies of innate superiority, difference, or deviance.

Sexuality and Health

Lived experiences of sexuality accordingly can affect health by pathways involving not only sexual contact (e.g., spread of sexually-transmitted disease) but also discrimination and material conditions of family and household life.

Power is a central concept in sexuality and affects how male and female sexuality is expressed. Gender power relations are central to sexual relations and also influence vulnerability to disease.

3. **Facilitator generates a discussion on Violence against Women, its various forms and effects on health.**

After an open discussion, the presentation highlights the following:

What is Violence against Women?

"Any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering, including threats of such act, coercion or arbitrary deprivation of liberty, whether in public or private life" United Nations (1993)

Forms of gender-based violence

- Physical violence
- Sexual violence
- Threat of physical or sexual violence
- Psychological/ emotional violence
- Sexual harassment

Violence throughout the Lifecycle

Foetus - sex-selective abortion

Childhood - Deprivation of and discrimination against the girl child, child sexual abuse

Adolescence - trafficking of young girls, violence at workplace, sexual abuse and rape, unwanted pregnancy.

Reproductive age - Violence against pregnant women, wife beating, torture for dowry, dowry murder, marital rape, rape and sexual abuse, violence at work place, forced pregnancy, forced abortion, coercive population control and family planning programs sponsored by the State.

Old Age - abuse of aged, desertion.

Health Effects of Violence against Women

Types of Violence	**Health Effects**
Childhood sexual abuse	Gyanecological problems, sexually transmitted infections (STIs) HIV, infertility, unwanted pregnancy, abortion, high-risk behaviors, substance abuse, attempted or completed suicide, death.
Rape	Unwanted pregnancy, abortion, pelvic inflammatory disease, infertility, STIs, partial or permanent disability, chronic pain, gastrointestinal (GI) disorders, headaches, HIV, attempted or completed suicide, death.
Intimate partner violence	Poor nutrition, exacerbation of chronic illness, substance abuse, obesity, GI problems, depression, brain trauma, organ damage, partial or permanent disability, chronic pain, unprotected sex, pelvic inflammatory disease, gynaecological problems, pregnancy complications, miscarriage, adverse pregnancy outcomes (including low birth weight and maternal death), attempted or completed suicide, death.

What prevents identification in the health systems?

- ➔ Time constraints faced by health care providers
- ➔ Cultural reasons\gender bias within health providers
- ➔ Feeling helpless, isolated
- ➔ Notion that violence against a woman is a private issue
- ➔ Lack of communication skills amongst health providers
- ➔ Poor referral services
- ➔ Bio-medical approach

Critical role of health providers

- Overlooking abuse could lead to poor quality of diagnosis and evaluation
- Failure to recognize results in repeated visits
- Screening and early interventions are far less costly than continuing to treat injuries
- Chance of preventing even more serious physical, psychological and social consequences
- Inappropriate or unnecessary medical treatment may contribute to a woman's sense of revictimisation
- Battering escalates over time, if neglected and can result in death by murder or suicide

Key points

Both sexuality and violence against women are under studied and under addressed aspects of women's health, with far reaching consequences. Gender and power relations are intrinsic in both sexuality and violence against women.

Readings

1. Violence against Women: Myths and Facts of Violence against Women (Pamphlet) Sakshi.
2. Violence as a Public Health Issue. Tathapi
3. Violence Against Women: Health Consequences
4. TARSHI, (2001). Common Ground: Sexuality. Principles for Working on Sexuality. New Delhi: TARSHI and SIECUS, pp. 7-8.

Based on the session developed by Renu Khanna.

Session 7: What are Rights?

Learning Objectives

The participants will be able to:

- Describe the concepts of rights, human rights
- Know the history of human rights

Methodology: 1. Participatory exercise 2. Presentation and discussion

Time: 90 minutes

Activity

1. **Participatory exercise.** Participants are asked to write on cards the rights that are most important to them. The cards are then categorized and put up. Some of the following are rights listed by participants as most important

Type of right
Right to speak/ Right to express oneself / Right to expression one's own opinion/ Right to speak, share / Right to express / Freedom of expression
Right to mobility/ Right to roaming/ Right to travel / Freedom of movement
Right to survival/ right to life
Right to education/ Freedom of education / Educational right
Right to freedom
Right to livelihood / Right to employment / Employment right
Right to make my own choices / Freedom of choice
Right to health / Right to good health
Right to basic needs
Right to equality / Right to equality and justice
Right to vote

Right to dignity
Right to space
Right to all fundamental rights
Freedom of living
Right to equity
Right to living with family
Right to enjoy
Cultural right
Right to information
Right to decide my life the way I want
Selection of life partner
Right to resources
Rights to have Rights and ask for them and express them in our way (Right to fight for rights)

2. Participants are divided in two groups. One group is asked to read Fundamental Rights guaranteed in the Constitution of India and the other the Universal Declaration of Human Rights. While reading, they are asked to reflect on the rights that they had written.

3. In the plenary, the facilitator discusses the important rights listed by the participants in relation to the Fundamental Rights and the rights mentioned in the UDHR.

4. Facilitator presents the history of human rights and the important human rights conventions.

5. Facilitator ends with

> *In Germany, the Nazis first came for the communists, and I did not speak up, because I was not a Communist. Then they came for the*

Jews, and I did not speak up, because I was not a Jew. Then they came for the trade unionists, and I did not speak up, because I was not a trade unionist. Then they came for the Catholics, and I did not speak up, because I was not a Catholic. Then they came for me...and by that time, there was no one to speak up for anyone.

-- Martin Niemoeller, Pastor, German Evangelical (Lutheran) Church

(Source: http://www.hrweb.org/intro.html)

Key points

- *Human rights refers to the concept of human beings as having universal rights, or status, regardless of legal jurisdiction, and likewise other localizing factors, such as ethnicity and nationality.*

- **History of human rights**

    - In the eighteenth and nineteenth centuries in Europe several philosophers proposed the concept of "natural rights," rights belonging to a person by nature and because he was a human being, not by virtue of his citizenship in a particular country or membership in a particular religious or ethnic group. Some viewed it an underlying principle on which all ideas of citizens' rights and political and religious liberty were based.

    - Out of the French Revolution came the "Declaration of the Rights of Man." The term natural rights eventually fell into disfavor, and the concept of universal rights took root

    - Universal Declaration of Human Rights, and Human Rights covenants were written and implemented in the aftermath of the Holocaust, revelations coming from the Nuremberg war crimes trials, the atomic bomb, and other horrors of World War II.

- Collapse of Soviet Union and East European countries in 1990s saw the emergence of Human Rights in a big way in global discourse.

There are 6 categories of rights in the UDHR

A. *Security rights that protect people against crimes such as murder, massacre, torture, and rape;*
B. *Liberty rights that protect freedoms in areas such as belief, expression, association, assembly, and movement;*
C. *Political rights that protect the liberty to participate in politics through actions such as communicating, assembling, protesting, voting, and serving in public office;*
D. *Due process rights that protect against abuses of the legal system such as imprisonment without trial, secret trials, and excessive punishments;*
E. *Equality rights that guarantee equal citizenship, equality before the law, and nondiscrimination; and*
F. *Welfare rights (or "economic and social rights") that require provision of education to all children and protections against severe poverty and starvation.*

Features of Human Rights

- *Human rights are political norms dealing mainly with how people should be treated by their governments and institutions.*
- *Human rights are minimal standards. They are concerned with avoiding the terrible rather than achieving the best.*
- *Human rights are international norms covering all countries and all people living today.*
- *Human rights have robust justifications that apply everywhere and support their high priority. Without this they cannot withstand cultural diversity and national sovereignty.*
- Negative human rights denote actions that a government should not take. They include limiting freedoms of speech, religion and assembly.

- Positive human rights denote rights that the state is obliged to protect and provide. Examples of such rights include: the rights to education, to a livelihood, to legal equality.

- Rights imply that there are Right holders -- a person or agency having a particular right. – And Duty bearers – usually governments, who are assigned duties or responsibilities to protect, fulfill and promote rights.

- **First, Second and Third generation of Human Rights**

  - First-generation human rights deal essentially with liberty and participation in political life. They are fundamentally civil and political in nature, and serve to protect the individual from excesses of the state. First-generation rights include, among other things, freedom of speech, the right to a fair trial, freedom of religion, and voting rights.

    The **International Covenant on Civil and Political Rights** is a United Nations treaty based on the Universal Declaration of Human Rights, created in 1966 and entered into force on 23 March 1976.

- Second-generation human rights are related to equality. They are fundamentally social, economic, and cultural in nature. They ensure different members of the citizenry equal conditions and treatment. Secondary rights would include a right to be employed, rights to housing and health care, as well as social security and unemployment benefits. Like first-generation rights, they were also covered by the Universal Declaration of Human Rights. International Covenant on Economic, Social and Cultural Rights, 1966 (entered into force 1976).

- Third-generation human rights are those rights that began to be defined in the subsequent decades, in various UN Conferences, including the 1972 Stockholm Declaration of the United Nations Conference on the Human Environment, the 1992 Rio Declaration on Environment and Development. Examples of the third generation of human rights are the Convention on the Elimination of all Forms of Discrimination against Women (the CEDAW Convention) and the United **Nations Convention on the Rights of the Child**, often referred to as **CRC** or **UNCRC.**

- **Women's human rights**

  - Political term used to underscore that women's rights are HUMAN RIGHTS, rights to which women are entitled simply for being human. This approach adds both a focus on women into the human rights movement and an emphasis on HUMAN RIGHTS PRINCIPLES into the women's rights movement.

Readings

1. Fundamental Rights (From Part III of the Constitution of India)
2. Universal Declaration of Human Rights. Adopted and proclaimed by General Assembly resolution 217A (III) of 10 December 1945.

Based on session developed by N.Rajaram.

Session 8: Applying the Rights Approach to Health

Learning Objectives

Participants will be able to:

- Describe right to health and health care, reproductive rights and sexual rights
- Apply these concepts to maternal health

Methodology: 1. Reading: (a) ICESCR General Comment-14, (b) CEDAW, (c) WHO Occasional Paper No. 5, Advancing Safe Motherhood through Human Rights.
2. Group work on case study analysis. 3. Presentations and discussion

Time: 90 minutes

Activity

1. Individual or group reading.

Participants are given the readings for homework. They have to familiarize themselves with the contents of the papers and be ready to apply them to the case studies the next day.

2. Group work on analysis of the case studies.

Each group is given a case study of denial of right to maternal health care with questions to be answered. The case studies and questions are in annexure 1. The group presentations should not exceed 10 minutes each.

3. Facilitator summarizes with a presentation that highlights.

- the differences between right to health and right to health care,
- the components of the right to highest attainable standards of health
- Reproductive and sexual rights

- The right to health must be understood in indirect terms as a right to the enjoyment of a variety of facilities and conditions necessary for the realisation of the highest attainable standard of health.
- The effective realization of the right to health is strongly related to and dependent on the realization of other economic, social and cultural rights. *E.g. Rights to food, housing, safe working conditions, and education.*
- The notion of "the highest attainable standard of health" refers to both the individual's biological and social preconditions and a State's available resources.
- The components of the highest attainable standard of health are: Availability, Accessibility, Acceptability and Quality.

(1) Availability refers to the existence of health facilities, goods and services to meet the basic health needs of the people including hospitals and clinics, trained medical personnel, essential drugs, and so forth.

(2) Accessibility means that health facilities, services and goods must be *within physical reach* for all parts of the population, especially for vulnerable groups such as ethnic minorities and indigenous populations, women, children, adolescents, the elderly, persons with disabilities, and persons with HIV/AIDS and other diseases that have an element of stigma attached to them.

- Accessibility requires *non-discriminatory access* to health facilities, services and goods for all segments of the population.
- Accessibility also implies that medical services and underlying preconditions of health, such as clean water and adequate sanitary facilities, are *within reasonable distance* even in remote rural areas.
- Furthermore, accessibility includes the right to seek and be provided with relevant *information* concerning all kinds of health

issues. However, accessibility of information may on no account impair the right to have personal health data treated with *confidentiality*.

- Requires that health facilities, services and goods be affordable for all.
- Arrangements for payment for health care services as well as services related to the underlying preconditions of health be based on the principle of fair financing ensuring that these services, whether privately or publicly provided, are affordable for all, including the socially disadvantaged groups.
- Fair financing means that poorer households should pay a smaller proportion of their income for health care services compared to richer households.

(3) Acceptability: Cultural appropriateness signifies that health policies must be at once respectful of the people's culture and aimed at improving people's health status. Health services should also be acceptable from the perspective of Medical Ethics.

(4) Quality

- Means that health facilities, services and goods must be scientifically appropriate.
- This requires skilled medical personnel, scientifically approved drugs and hospital equipment, clean water and adequate sanitation, sufficient information on environmental hazards and health risks.

Women's Right to Health Aside from the complexities associated with the right to health in general, consideration of the right to health of women needs to take into account at least two additional dimensions. Women's right to health must be considered from a gender perspective. In addition, the prohibition against discrimination must be kept in mind. Both dimensions are considered in article 12 (1) of CEDAW relating to guarantees of access to

health services without discrimination, and article 12 (2) related to maternal health services. Access to reproductive health services is also referenced in the CRC (article 24[2][d].

- **Reproductive rights** "embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health"

  (ICPD POA, para. 95).

- **Sexual rights** are a fundamental element of human rights. They encompass the right to experience a pleasurable sexuality, which is essential in and of it, and, at the same time, is a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality.

  (Source: HERA)

The concept of sexual rights, like that of human rights, provides a framework to ensure non-discrimination, and therefore cannot be used to privilege one individual or group over another.

Sexual rights affirms entitlements, such as the right to bodily integrity, as well as rights that protect against violations, such as the right not to be coerced into sexual activity.

OTHER IMPORTANT GENDER TERMS

Gender Development Index (GDI): Measures developments of states according to the same broad factors as the HUMAN DEVELOPMENT INDEX, but highlights the inequality in these spheres between men and women.

Gender Discrimination: Discrimination based on socially constructed ideas and perceptions of men and women.

Gender-Neutrality: Treatment of a problem without recognition of gender; myth of gender neutrality in human rights eliminates recognition that treating people identically despite unequal situations perpetuates rather than eradicates injustices.

Gender Perspective: Notion that problems and solutions should be examined with sensitivity to the implications of gender in mind. This concept is based on an understanding that in all situations some perspective of interpreting reality is present. Historically, that perspective has most often been biased towards the male view and, accordingly, most perspectives on reality have not taken women's views and experiences into account, rendering the every day violations of women's human rights invisible.

Gender-Specific Claims: Human rights claims relating to abuse women or men suffer because of their gender, when HUMAN RIGHTS are being violated due at least in part to a person's gender and/or when women's experience of a human rights violation differs from men's experience due to gender-specific consequences or experiences.

Key points

What is meant by a rights-based approach to development?

"As rights-based approach to development sets the achievement of human rights as an objective of development. It uses thinking about human rights as scaffolding of development policy. It invokes the international apparatus of human rights accountability in support of development action. In all of these, it is concerned with not just civil and political rights but also with economic, social and cultural rights. Further, the implementation of a rights-based approach implies that performance standards be set."

"A rights-based approach to development describes situations not simply in terms of human needs, or of developmental requirements, but in terms of society's obligations to respond to the inalienable rights of individuals, empowers people to demand justice as a right, not as charity, and gives communities a moral basis from which to claim international assistance when needed."

UN Secretary General,
Kofi Annan

Readings

1. The right of the Highest Attainable Standard of Health, General Comment 14.
2. Right to Health in International Documents.
3. Convention on the Elimination of All Forms of Discrimination Against Women.
4. UNICEF, Regional Office for South Asia. (2003). A Human Rights-based Approach to Programming for Maternal Mortality Reduction in a South Asian Context. A review of Literature. Geneva: UNICEF, pp. 100-106.

Based on session developed by Renu Khanna.

Annexure 1 - Case studies on Maternal Health

Case study 1: Kokilaben Nayak, age 30, resident of Jhapatiya village, Dahod district, Gujarat, was pregnant with her first child. As she had completed her term of pregnancy, and would soon go into labour, her husband, Maheshbhai, arranged for a private jeep to shift her to the CHC at Baria by hiring a private jeep from the village to Baria, spending Rs.500 on transport.

Soon after Kokilaben was admitted there, all the CHC staff left for the day. The gynecologist at the CHC (M) told Maheshbhai that his wife would have to undergo a caesarian operation, demanded Rs. 4000-5000. Maheshbhai's suspicions that the doctor was trying to make money was reinforced when he was asked to buy three 'labour-inducing" injections that cost Rs. 150 each from a medical store. He also observed that Kokilaben was not given the injections he bought. Finally, when a nurse manhandled Kokilaben and caused the bone in her leg to crack, he decided to shift her. The staff of the CHC tried to stop them, but Maheshbhai was defiant. They spent the night under a tree and in the early hours of the morning on the next day, he had his wife admitted in a private clinic in Baria, where Kokilaben had a normal delivery. The total expenditure at the private clinic amounted to around Rs.1500. Maheshbhai spent Rs.525 to take his wife to her natal home in a jeep.

Case study 2: Reshamben, age 30, resident of Fangiya village of Dahod district, Gujarat, delivered a baby boy at her home. The birth was attended by an untrained 'dayan' (traditional birth attendant). Reshamben suffered postnatal complications. She became weak and listless, the placenta was not expelled even after seven days, her legs were swollen, and she became unconscious. Her husband rushed her to the CHC, in a private jeep, spending Rs.400 on transport.

She stayed there for three days, during which period, her husband spent around Rs.1200 on buying all the drugs, IV fluids prescribed to her from pharmacies as the CHC did not have these in stock.

When her condition improved a little, Reshamben was taken home, but after two days her condition deteriorated again, and her family shifted her to the civil hospital at Godhra spending Rs.1500 on private transport. Meanwhile, Reshamben's neighbors victimized the birth attendant (as is common practice in this region), accusing her of being a 'dakan' (witch) and casting an evil eye on her.

At the Godhra civil hospital, the placenta was removed. Reshamben stayed there for four days, still unconscious, with hardly any improvement in her condition. As the medical staff was uncommunicative about her condition, her husband shifted her to a private clinic in Godhra. She recovered after 14 days of intensive medical care in the private hospital. By then her family had spent more than Rs.17000, having sold off their shop in the village, taking a loan of Rs.3000 from the self help group.

Case study 3: Jashodaben, age 28, resident of Santrampur (Panchmahals district), Gujarat, had a girl child. She registered under the local PHC for primary care including antenatal care. The health worker advised her to approach the CHC doctor if she had any complaints during pregnancy. When she consulted the CHC medical officer she was told that she was carrying twins, but later an ultrasound test done in a private hospital showed that there was no second twins, but the position of the fetus was not normal. She was advised to go for an operation immediately, which she could not follow due to acute financial constraints. On her way back home, she felt labour pains. As if was midnight, her husband decided to shift her to the civil hospital at Godhra the following day. The nurse of the Godhra hospital informed her husband that the doctor was not available and could visit her only in the next day morning. There was no doctor for the emergency.

However, by midnight Jashodaben went into labour. The nurse helped Jashodaben in the emergency. She administered a saline intravenous infusion and assured them that the delivery would be safe. But it was a stillbirth. The nurse prescribed four injections, which cost Rs 90 each. She gave her some more IV fluids and prescribed another two injections that cost about Rs. 7000. Jashodaben's husband could not find one of the prescribed injections at such an early hour, as nearby medical shops were closed. Jashodaben's 'veins started straining' and she died because life-saving injections were not made available to her on time. Her husband paid Rs.650 to the hospital ambulance authority to bring home Jashodaben's body.

Case study 4: Jiwiben, age 40, resident of Santrampur (Panchmahals district), Gujarat, has a son and a daughter. She had undergone sterilization at a health camp, where she was operated upon by the medical officer of the CHC. The neither the camp organizers nor the CHC provided any transport facility to her to reach home safely. Three years later she got pregnant again and become very weak and this caused tension in the family. When she went to get her case number of her operation, which she needed for further treatment, the clerk demanded hundred rupees to release the case number. She paid the clerk with help from her village headman.

Later she was admitted in the same hospital for her delivery and she stayed there for a week. On discharge from the hospital she fainted. Her husband took her to a nearby private hospital. She was very weak and lodged a complaint against the doctor of the hospital for all the harassment.

Now, she thinks she has an abdominal tumor but does not want to go to the government hospital for treatment fearing that the doctors there would harass her as retaliation against the complaint she had lodged. She is also not in a position to go anywhere else due to acute financial crisis.

Session 9: Review of Module 1

Learning Objectives

The participants will be able to:

- Clarify their doubts related to the concepts included in this module.
- Identify how the various concepts are related.

Methodology: 1. Questions and answers and 2. Quiz

Time: 90 minutes

Activity

1. Facilitator starts by asking participants to list questions that they may have based on the contents of the module. Other participants are encouraged to answer these questions. The facilitator then summarises the responses.

2. Through a quiz, the facilitator promotes a recall of the concepts covered in Module 1.

Module 2

Researching Gender and Social Issues in Health

Learning objectives

1. Describe the paradigms of research.
2. Describe step by step the research process, beginning with identification of research gaps, developing research questions, selecting appropriate study design, data analysis and report writing.
3. Use the gender analysis tool in the research process.
4. Apply gender analysis framework to specific health conditions.

Session 10: Research Process: Step by Step

Learning Objectives

The participants will be able to:

- Define steps/stages in research
- Identify research gaps
- Formulate research questions
- Select an appropriate study design and research methods to answer the research question

Methodology: 1. Interactive presentation and discussion, interspersed with examples of gendered research.

Time: 120 minutes

Activity

Presentation

1. Introduction: Difference between Basic and Applied Research

Basic Research

- Basic research is done to understand society and to be able to explain societies and their organization. It is also done to be able to predict and use research for ordering or organizing society.
- Several kinds of research are there - exploratory, descriptive, explanatory etc. These all are part of basic research.
- When one sees a new set of phenomena happening in a community one may want to know the reason for it. So one goes into an exploratory phase to try and understand it.

Applied Research

- Large scale base line surveys to anchor programs and/or monitor changes (Census, NSSO, NFHS, DHS, etc.)
- Evaluation & Monitoring Research: to assess program performance and introduce course corrections or cease the initiative
- Needs assessment and Rapid Appraisals
- To understand and influence behavior, if necessary (social engineering market research)

Research for Change

- Research that involves the 'subjects' of research in the process of research
- For facilitating awareness building through the production of knowledge ground up
- For breaking the researcher - researched dyad
- For stating that research, production of knowledge and theory building are political processes
- To demonstrate that research can have emancipatory goals.

2. What is the role of Theory in Research?

Role of theory in research

- Theory is an explanation of how the facts fit together. Theory is what makes sense out of facts and gives facts their meaning. Without theory, facts remain a clutter of disorganized information. Theory on one hand serves as a background for empirical research, and on the other it also strengthens the empirical data. The most commonly known meaning of theory is "an explanation of observed regularities."
- Theory can be depicted as something that precedes research (as in quantitative research) or as something that emerges out of it (as in qualitative research). Theory and research are linked in two ways: deductive and inductive reasoning. A researcher can derive testable

hypothesis from the theory for conducting a research. At the same time one can formulate a theory after conducting a research. Thus the social research and theory are linked through the two ways, one is deriving hypotheses and second is developing generalization from observations (i.e., developing a theory).

- Theory increases a researcher's awareness of interconnections and of the broader significance of data.
- A Sample is an illustrative example.
- Methodology means body of methods used in a particular activity. It is a science of method.

3. What is the role of Concepts?

- Concepts are the building blocks of Theory
- Concepts are on a continum of being concrete to abstract (age, school, housing..... social control, autonomy, decision-making etc)
- Well defined concepts (where they exist) and operational definitions (where they are being explored) help link theory with research.

4. Research Objectives and Questions

- Research Objectives state the goals of doing the research, the relationship or association of which concepts is being examined
- Research Questions pose not only the relationship of variables but also their direction and strength of association. For eg: Do older women in a household have more access to health services than younger women? Do educated women perceive more problems with menstruation than uneducated women?

5. What are the sources of Research Questions?

- Past Research - comprehended through Literature Review
- Casual Observation of Human Behavior
- Social Policy
- Sociological Theory

6. Methodological Issues

- What is the universe?
- What is the sample?
- What is the study design?
- What are the sources of data?
- Where is the study located? - community based; hospital based;

7. What is a Research Design?

- Research design is a term used for the steps that you follow to capture a replica of the larger universe that you are attempting to study.
- For a study on infertility: if your research questions make a distinction between literate-illiterate women; 'employed' women and 'housewives'; women in nuclear and joint households, for example, then your design should capture all these categories through your house listing.

8. What is the Universe?

- Example: Study on treatment seeking behavior of infertile women
- Operational definitions for: (a) what is considered "treatment seeking behavior"? (b) Who are considered as "infertile women"?
- UNIVERSE is women currently married, co-habiting, not using any form of contraception for the past two years and not pregnant.

9. What is the Sample?

- Sample for a study is linked to the frequency of the episode (in this case infertility) in a population.
- The more frequent the episode; you will be able to capture it in a small sample. For e.g., gynaec morbidities vs. maternal mortality
- If it is a community based study, the sample will have to be selected after a house listing of all currently married couples and identification of households as per your definition.
- More the parameters of the study the more complex is your research design.

10. What are the tools of Research?

- Survey Research
- Participant Observation
- Interviewing
- Controlled Experiments
- Content Analysis
- Comparative and Historical Research
- Evaluation Research
- Prediction and Probability

11. Frequently used Research Methods

- Quantitative Methods: structured, coded questionnaires, open-ended interview schedules. Ensure they are pilot tested and refined.
- Qualitative methods.
- Most studies use quantitative and qualitative method mix.

12. Data Collection

- Not a value free exercise.
- Ethical issues need to be factored in.
- Gender, class, caste and other indices of social positioning get played out in the field - need to be alert.

13. Data Analysis

- ***Quantitative Data Analysis*** :

Need to spend time to 'clean' the data; manually code or computerize the data. Recode open ended questions. Prepare a code book to correspond to the schedule. Simple to complex statistics are made possible with SPSS package to ascertain relationship and association of variables.

- ***Qualitative Data Analysis:***

It is the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships.

Analytic induction and grounded theory are the most frequently cited approaches in qualitative data analysis. Both are iterative approaches, which mean there is repetitive interplay between the collection and analysis of the data. Grounded theory and analytic induction can also be viewed as strategies for collection of data. Some other forms of analysis are content analysis, discourse analysis and narrative analysis.

Some software like NVivo NUD*IST, Gofer, ATLAS.ti, RDBMS, ZyINDEX are helpful in analyzing qualitative research data.

Qualitative data is analyzed in three linked steps:

Data reduction: The data is transcribed in written form for a detailed study and verbatim are preserved to retain the meaning of the data. Data is summarized and coded and themes and conceptual categories are formed.

Data display: The data is then represented in form of data reduction charts, figures, diagrams, matrices, tables etc. This gives a basis for thinking further about and helps in further interpretation of the data. Concept mapping is an important part in data display. It is a visual representation of relationship of concepts/themes. Missing data and invalid data has to be checked for, in this process.

- ***Conclusion and Verifications***: Qualitative research involves interpretation of data or drawing meaning from the data display. Triangulation of methods of recording the patterns of data, confirming the doubts in the data, following up with the participants/respondents is generally used for interpreting the summarized data.

14. Interpreting Data

- Analyzing and Interpreting data is closely linked
- Interpreting data is closely linked to the theoretical perspectives that you subscribe to
- Going back to reading relevant literature and understanding how your findings are intervening in the existing debates or current knowledge or policies is important.

15. Report writing

- Different outputs from research have to be planned before, while and after doing research.
- Reporting of research findings is basically part of communicating and sharing your work with the larger academic community.
- Accountability to the community from whom data has been collected is a neglected issue, but needs to be considered.
- One research often sows the seeds for the next enquiry!

Flowchart depicting Steps in Research Process

1. Difference between Basic and Applied Research

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2. What is the role of Theory in Research?

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3. What is the role of Concepts?

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4. Research Objectives and Questions

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5. What are the sources of Research Questions?

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6. Methodological Issues

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7. What is the Research Design?

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8. What is the Universe?

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9. What is the Sample?

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10. What are the tools of Research?

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11. Frequently used Research Methods

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12. Data Collection

↓

13. Data Analysis

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14. Interpreting Data

↓

15. Report writing

Readings

1. Bhopal, K. (2000). Gender, 'Race' and Power in the Research Process: South Asian Women in East London (Chapter 5). In C. Truman, C., D. Mertens, and B. Humphries (Eds.), Research and Inequality. USA and UK: UCL Press, pp. 67-79.
2. Health Canada. (2003, June). Exploring Concepts of Gender and Health (Chapter 5: The Research Process and Gender-based Analysis). Ontario: Women's Health Bureau, Health Canada, pp. 12-15.
3. Kitts, J. and Roberts, J.H. (1996). The Health Gap: Beyond pregnancy and reproduction (Chapter 3: The Research Process). IDRC

Based on the session developed by Lakshmi Lingam.

Session 11: From Research Ideas to Research Questions

Learning Objectives

The participants will be able to develop skills of translating research ideas into research questions.

Methodology: Group work around participants' own research studies

Time: 90 minutes

Activity

1. Group work

Each group is asked to select one research study from amongst the participants' own work. Once they decide on the Title, they should generate research objectives, research questions and prepare a presentation.

Each presentation is discussed and the resource person gives feedback to sharpen the research idea, the objectives and the research questions.

An example from the participants

Title: Evolving HIV/AIDS Counseling Model for MSM *(Men having sex with Men)* population.

Research objectives

- To study the sexual behaviour of MSM population of Vadodara city.
- To identify psychosocial issues of MSM population
- To identify their coping mechanics
- Based on the above three, to formulate a working model of HIV/AIDS Counseling.

Research questions

- Is the sexual behavior of MSM population different from heterosexual population?

- Are there any differences in the sexual population from heterosexual population? If yes, which are they?
- Are the vulnerabilities associated with the homosexuals different from heterosexual population?
- Are the psychosocial issues of MSM population different from heterosexual population?

Methodology: FGDs, In-depth Interviews, and Questionnaires.

Possible feedback from the resource person

1. The title indicates a goal or an outcome. Title should be what one wants to explore. Here the title could be "to study the sexual behavior and psychosocial issues of MSM population in Vadodara city." Title should match with the objectives.
2. The research questions should be worded differently, looking at the relationships between variables.
3. It is important to keep checking whether the research questions are within the realm of objectives. Also the research questions should be logically linked to the objectives. Objectives are at a higher level of abstraction and have a larger goal.

Based on the session developed by Lakshmi Lingam and Sundari Ravindran.

Session 12: Literature Review

Learning Objectives

Participants will be able to:

- Write a good literature review

Methodology: Group exercise, presentation

Time: 90 minutes

Activity

1. Group exercise

Participants are given annotations of two or three articles. They are asked to read through the annotations and individually create labels to indicate what each paragraph talks about, i.e. each paragraph has to be given a title.

Paper 1 - 'A Profile of Women's Work Participation Among the Urban Poor of Dhaka, Bangladesh'

Labels that could be given by participants

- Profile and socio demographic characteristics of the participants in the study.
- Gender based restrictions on women being challenged though cultural practice of domination by the powerful continued.
- Gender division of labour.
- Variation in work participation by marital status and age.
- Men's control over women's work and mobility, gender and power, decision making.

Paper 2 - 'Intermittent Employment among Married Women: A Comparative Study of Buenos Aires and Mexico City, Latin America'

Labels that could be given by participants

- Women's work participation in relation to presence of children in the household and support structure.
- Women's work participation with respect to husband's work status.
- Women's education and labour work participation.
- Traditional expectations and married women's work participation.
- Women's perception of their paid work and family circumstances, labour market, economic and social conditions.

2. Presentation by Resource Person

Purposes of Literature Review

- Find gaps in the literature
- Avoid reinventing the wheel
- Build on the platform of existing knowledge and ideas
- Learn about other people and networks in the same field
- Identify important works about your topic
- Provide intellectual context for your own work to position your work
- Learn about opposing views
- Identify research methods relevant to your research

Literature Reviews: Research Articles - Review Papers

- Literature Reviews attempts to capture the "big picture" of a field of research.
- Research Articles are based on empirical studies. The introduction provides a condensed literature review to provide the rationale for the study that has been conducted.
- Review papers provide the state of art in a particular area, along with an assessment of theory that is getting built or policy that the research does or does not support.

Steps in Developing a Literature Review

- Three main steps:
    - Select a research topic
    - Collect and read relevant articles, and
    - Write the review.

Other issues

Literature review is like 'standing on the shoulders of one's predecessors'. Nothing that a researcher sets out to do would be absolutely new. Some work would already have been done on the issue, though perhaps from different vantage points. There could be different disciplinary interventions.

Through literature review the researcher would be able to say what was known and what was not known. Based on this, the researcher would narrow down on what s/he is interested in, giving the rationale for the chosen research problem. Then the researcher will state the objectives and formulate research questions. Finally the research design will be generated so that all the information is put in place logically.

An example

The resource person gave an example of a study on 'breast-feeding practice' that she undertook with a colleague. While doing the literature review they found that work on breast-feeding had been done mainly by three groups of people. One was the demographer who looked at the positive linkage between breast feeding and fertility decline. Thus their focus was exclusive breast-feeding for the purpose of population control. The second group of people was the pediatricians. For them breast-feeding was crucial for child survival and the woman's importance was only to feed the child. Thus the 'mother' as a 'woman' was absent from their point of view. The third group also focused on child survival and linked it with policy matters and issues like baby-friendly hospitals and large pharmacies advertising tinned food. Thus it was found that focus on women was actually absent in all the work that had been done on breast-feeding. There was no talk of the support structures that women would need in order to breast-feed, especially those women who work outside the home. The resource person said that therefore a researcher needed to look at the existing literature from a perspective that came from the researcher's standpoint and theorizing. Thus in their study on breast-feeding practice they concluded that enough of research was already done, and what was needed was a supportive policy and necessary enabling environment for women to be able to breast-feed.

Literature review has to be organically linked to the study. It should not be confined to, 'who said what is which book'. One should go through literature review in stages:-

- Build a perspective.
- Give an overview - what are the relevant policies, what data has been generated so far, etc.
- Give empirical studies (studies done in particular places)
- Make policy/programmatic linkages.

While doing literature review one could write annotations - that is, write down separately what the paper is about, what are its research questions, and where the study was located. One could also do 'paper review at a glance' in a tabular form:

Literature Review at a Glance

Sr. No.	Author	Journal	Location of study	Sample size	Remarks
					Put most salient points of the paper here

If the researcher has read 50 papers, s/he would not have to go back to all the 50 papers, unless any of them seemed really interesting or close to one's study.

To organize the literature review, portions about the same aspect from different papers could be copied and pasted in one place under a suitable heading. For instance, portions related to 'cultural practices' could be copied and pasted from different papers under the head 'cultural practices and women's work', followed by the references of the papers.

Readings

1. Neuman, L. W. (2000). Reviewing the Literature and Writing a Report (Chapter 16). Social Research Methods: Qualitative and Quantitative Approaches (4th Edition). Boston: Allyn and Bacon, pp. 445-480.

Based on the session developed by Lakshmi Lingam.

Session 13: Paradigms of Research

Learning Objectives

Participants will be able to:

- Describe the origin, types and paradigms of social science research

Methodology: 1. Small group exercise 2. Presentations 3. Revisiting the initial exercise, 4. Participants' sharing of their own studies in relation to paradigms of research.

Time: 240 minutes

Activity

1. Exercise

The participants are given eleven statements And asked to indicate Whether they agreed or disagreed with each of those, giving Reasons for their responses.

1. Scientific research must be value-neutral.
2. The researcher and researched must maintain a distance.
3. Scientific research aims at control and prediction.
4. Scientific research aims at universal laws.
5. Methods of natural sciences can be directly applied to the study of human behavior.
6. Different social groups view the world differently.
7. The aim of scientific research with human beings is to understand and explain.
8. All research must attempt to change gender relations.
9. To do research, it is imperative to have been trained in scientific methodology.
10. Feminist research essentially means including women in the sample group.
11. Only women can do feminist research.

2. Presentation

(i) Defining Paradigm

"A [paradigm] is a shared way of apprehending the world. Embedded in language, it enables those who subscribe to it to interpret bits of information and put them together into coherent stories or accounts" (Dryzek, 97, p. 8).

Paradigm is the basic belief system or worldview that guides the investigator- the underlying layers at the back of the investigator's mind, using which s/he understands and interprets information. Theory is a subset of paradigm.

Paradigms are fundamental frames of reference used to organize observations and reasoning.

(ii) Three important terms to understand the paradigms of social sciences

Ontology: This is to do with reality. If there is a "real" world, then what can be known about it? What is "real" is accepted.

Epistemology: This is to do with the relationship between the knower (researcher) and what can be/is to be known (phenomena being studied). The relationship is determined by the 'ontological' question. If we are studying the 'real' world, then as researchers we cannot influence, but if it is a 'constructed' world then the researcher can influence. If it is 'real', then the posture of the knower must be one of detachment so as to know how things work.

Methodology: This refers to the practical way of collecting data. If there is a "real" world, the "objective" researcher requires control of those factors which might influence the study.

Differences between Epistemology, Methodology and Ontology:

Epistemology is the theory of knowledge or how we know what we know. Central to epistemology is the question of where the authority of the knower comes from. Epistemology has always been of fundamental concern to feminist analysis, because feminism challenges man-made knowledge and seeks to establish new or alternative knowledge.

As Sandra Harding explains, methodological theory implies an analysis or an approach. A methodology is a theory and analysis of how research is done; it includes accounts of how the general structure of theory finds its application in particular scientific disciplines."

Ontology is a branch of metaphysics dealing with the science of being.

(iii) Paradigms of social science research

Positivism

With the assumption that there is a "real" world, it is aimed to study that world in order to control and predict. The researchers observe "reality", Test hypotheses, Establish cause-effect relations to arrive at universal laws. The researcher and researched are assumed to be independent entities without either having any influence on the other. When influence in either direction is recognized / suspected, various strategies are used to eliminate or reduce it.

The positivist paradigm has dominated the formal discourse in the physical and social sciences for the last nearly 400 years. But gradually people began questioning whether this is the only paradigm. As people started critiquing positivism, it gave rise to post-positivism.

Post Positivism

It believes in a critical realism, i.e. there is a reality independent of our thinking about it, which science can study. Post-positivist critical realist recognizes that all observation is fallible and has error and that all theory is revisable.

The belief is that the goal of science is to hold steadfastly to the goal of getting it right about reality, even though we can never achieve that goal. It emphasizes the importance of multiple measures and observations, each of which may possess different types of error, and the need to use triangulation.

Constructivism

It is based on relativist ontology, i.e. there is no 'one real world'. Realities are apprehendable in the form of multiple, intangible, mental constructions. They are socially constructed, and are experiential, local and specific in nature. The researcher and the researched are linked and the "findings" are "created" as the investigation proceeds. Methods used are dialectical or hermeneutical. This involves construction of the people's experiences with their "voices" through interactions between and among the researcher and respondents.

Post modernism

Knowledge is linked to time, place and social position from which individual constructs it. Terms of analysis are

- Text: The subject matter being analyzed is a text, like in a novel. The text has to be analyzed to find meanings that are mentioned and also those that are not mentioned.
- Discourse: This refers to the exchange of ideas and symbolic communication between participants and the thinking that underlies it.
- Simulacra: Simulation is such that there is no distinction between original and copy.
- Hyper reality: For example, a world where media, instead of reflecting reality, itself becomes reality.
- Deconstruction: To identify and unravel the various voices in a text and the differences those are not visible on the surface.

The question of emancipation does not exist in post modernist paradigm. Post modernists have no hope of change and are cynical. There are multiple realities, all truths co-exist and there is no coherence between them.

Therefore there is no one way of doing research in the post-modernist paradigm.

Feminist Paradigm

Feminist epistemology is based on the feminist way of looking at the world and focuses on the salience of gender. Gender is used as an analytic category in discussions, criticisms, and reconstructions of epistemic practices, norms, and ideals. Feminist epistemology very consciously centers on *women's* perspectives.

Feminist scholars' criticism of social science research was that:

- Women have been largely ignored in the traditional approaches to knowledge
- Andocentric bias: Even where women have been considered, their assessment has been done in masculine term.
- Subject-object dichotomy: There are definite unequal power relations between the researchers and researched with the researcher having the powers by virtue of training, research tools, etc.

Therefore the feminist approaches

- Identify ways in which dominant conceptions of knowledge systematically disadvantage women and other subordinated groups.
- Study ways in which gender does and ought to influence conceptions of knowledge and practices of inquiry. Women's perspective has to be brought in to understand how knowledge is incomplete.
- Strive to reform existing conceptions and practices in order to serve interests of neglected groups. The aim is to change existing frameworks to understand the relations and behaviours such that the views and perceptions of hitherto neglected groups are mainstreamed.
- Ground inquiry in concrete experience and everyday lives of all people unlike the earlier researches that had been very elitist.

Critical Theory

It rejects the idea of "objective" knowledge that was stressed upon in positivism. Instead believes that knowledge is socially constructed by people at a given point of time and is therefore relative. It is grounded in history and social structure. Critical theory aims to challenge prevailing oppressive social structures such as patriarchy. Its goal is to emancipate - it uncovers and questions aspects of ideologies that restrict or limit different groups' access to the means of gaining knowledge (for example, class and caste). It is the theory of, by, and for the participants of the study - the participants themselves say what their reality is. Voices of groups like women, dalits, tribals, are what matter the most.

Reform is a part of the agenda of critical theory. It moves a step ahead of constructivism to ask what should be done to bring about a positive change in the lives of the oppressed groups.

'Objective knowledge' implies that there is only one kind of knowledge and a single way of understanding situations/issues. This view is not accepted in critical theory. For example, the recent discourse in the arena of health, where allopathy is gaining supremacy over other systems of medicine is whether allopathic is the single way of healing. Similarly, while studying the health delivery system it is not only the health system's view that would be considered. The perspectives of service users, non-users and providers would collectively reflect the status of the system. If one wants to focus on a sub-set like single lesbian women then a married heterosexual woman may not be able to gather the necessary information effectively. Therefore lesbian women would themselves collect data and bring forth their own perspectives. In that sense they themselves become researchers.

Standpoint Epistemology - A Type of Critical Theory

A standpoint is a socioeconomic position from which social reality can be understood and from which emancipatory action can be undertaken.

It can be literally understood as the "view from where I stand". For example, dalit/tribal/rural/urban women would have different views of the world.

Members of more powerful and less powerful groups will have inverted or opposed understandings of the world. Less powerful members of society have the potential for a more complete view of social reality, precisely because of their disadvantaged position. For example, the domestic help who comes to work in the middle class households is in many ways less privileged than her employer. It is the domestic help who knows more about the employer's life, home, family, and daily schedule than the employer knows about her and her life. The Dominant group has a partial view because it is in the interest of the group members to maintain, reinforce and legitimize their own dominance and particular understanding of the world. They do not want to understand the problems of the 'other' as they are comfortable in their privileged position.

Feminist Standpoint Epistemology

Feminist standpoint theory takes the standpoint of women. The grounds of Feminist Standpoint Theory are as follows:

Centrality

- Because women tend to the needs of everyone else in the household, they are in a better position than men to see how patriarchy fails to meet people's needs.
- Men, by virtue of their dominant position, have the privilege of ignoring how their actions undermine the interests of subordinates.

Cognitive Styles

- Development of gender identities leads males and females to acquire distinctively masculine and feminine cognitive styles.
- Masculine cognitive style involves being emotionally detached, analytical, deductive, quantitative, oriented toward values of control or domination.

Feminine cognitive style involves being concrete, practical, emotionally engaged, qualitative, relational, and oriented toward values of care.

- Feminine cognitive style is considered epistemically superior because an ethics of care is superior to an ethics of domination.
- They will produce representations of the world in relation to universal human interests, rather than in terms of the interests of dominant classes.

Oppression

- Women are oppressed, and therefore have an interest in representing social phenomena in ways that reveal rather than mask this truth.
- They also have direct experience of their oppression, unlike men, whose privilege enables them to ignore how their actions affect women as a class.

Feminist Postmodernism

Within feminist paradigms also there are multiple views. Feminist Postmodernism emerged from a critique of feminism that it is elitist in its approach. It raises the questions that how can western upper class white women document realities of women from all over the world. It talks of the privilege that some women get over other women on the basis of their class and race. Therefore one group of women cannot have the privilege to research the realities of the other groups of women. Universal claims about gender and patriarchy are to be avoided. No single perspective is privileged above others; there is plurality of perspectives.

Participatory Research (PR)

Underlying perspectives of PR are:

- Paulo Freire's work in Latin America which raised the issue that traditional education does not address inequalities.

It is restricted to the elite. It is important that the marginalized and the powerless groups get such education that helps them understand how they are being oppressed so that they can liberate themselves of the oppression.

- Concept of 'critical consciousness': Empowerment to think and act on the conditions around oneself and relate these to the larger contexts of power in the society.
- The dichotomy between subject and object is broken.
- People themselves collect the data, and then process and analyze the information using methods easily understood by them.
- Research and action are inseparable – they represent a unity.
- Research is a praxis rhythm of action-reflection where knowledge creation supports action.
- The knowledge generated is used to promote actions for change or to improve existing local actions.
- The knowledge belongs to the people and they are the primary beneficiaries of the knowledge creation.
- There is a built-in mechanism to ensure authenticity and genuineness of the information that is generated because people themselves use the information for life improvement.

The key processes of Participatory Research

The promotion of participatory research is basically an exercise in stimulating the people to:

- collect information
- reflect and analyze it
- use the results as a knowledge base for life improvement, and
- whenever possible, to document the results for wider dissemination i.e., for the creation of a people's literature.

Participatory and Conventional Research - A Comparison

Dimension	**Participatory Research**	**Conventional Research**
What is the research for?	Action	Understanding
Who is the research for?	Local people	Institutional, personal, professional interests
Whose knowledge counts?	Local people's	Scientist's
Topic choice influenced by?	Local priorities	Professional interests, funding priorities
Methodology chosen for?	Empowerment, mutual learning	Disciplinary conventions, objectivity
Who takes part in the research process?	Local people	Researcher
Action on findings?	Integral to the process	Separate; may not happen
Who takes action?	Local people	External agencies
Who owns results?	Shared	Researcher
What is emphasized?	Process	Outcomes

(Adapted from Cornwall Jewkes, 1995)

Issue of validity in PR is very different from the way it is looked at in quantitative research. Some researchers have used the term 'trustworthiness' instead of 'validity'. In PR the researcher also goes back to the community and confirms that what she has written is in accordance with the people's responses and opinion.

3. Revisiting the initial exercise

The facilitator discusses the initial statements that the session started with. The participants' responses change significantly. The meaning and context of the statements are clearer to the participants after discussing the various research paradigms.

Sr. No.	Statement	Participants' response
1.	Scientific research is an objective enterprise	Not necessary
2.	Scientific research must be value-neutral	From feminist point of view it should be biased. The statement can be reframed - Scientific research need not be/ may not be value neutral
3.	The researcher and researched must maintain a distance	Not necessary
4.	Scientific research aims at control and prediction	No
5.	Scientific research aims at universal laws	Not necessary
6.	Methods of natural sciences can be directly applied to the study of human behavior	Not necessary, it can be so
7.	Different social groups view the world differently	Yes-Critical theory, Standpoint epistemology
8.	The aim of scientific research with human beings is to understand and explain	Yes-this is in contrast with the statement that scientific research aims at control/prediction
9.	All research must attempt to change gender relations	If from feminist paradigm, then yes
10.	To do research, it is imperative to have been trained in scientific methodology	Disagree, not necessary as in Participatory Research subaltern groups are not trained to do research

The exercise looks different when it is done the second time. The exercise is an example of the fact that when human beings mediate, they bring in aspects that are not intended to by the initiators.

It is reiterated that the aim of the exercise is to:

- Make the participants aware of different paradigms
- Give their limitations and strengths
- Establish that all theories are based in some or the other paradigm

The resource person stresses that one must learn to articulate what is the research paradigm that one is using, and how one may be diverting from the original paradigm.

4. Participants' sharing of their research studies

Discussion on various research paradigms will help participants identify the research paradigms being used by them in their respective studies Hence some of the participants are asked to present their research studies and identify the paradigm on which their study is based.

Readings

1. Guba, E. G. and Lincoin, Y.S. (1994). Competing Paradigms in Qualitative Research. In N.K. Denzin and Y.S. Lincoin (Eds.), Handbook of Qualitative Research. Thousand Oaks: Sage Publication, pp. 105-117.
2. Nielsen, J.M. (Ed.). (1990). Feminist Research Methods. Exemplary Readings in Social Science (Introduction). San Francisco: West View Press, pp. 1-37.

Based on session developed by Shagufa Kapadia and N.Rajaram

Session 14: Overview of Qualitative Methods

Learning Objectives

The participants will be able to:

- Describe the basic principles of qualitative methods
- Develop skills to use qualitative methods in a gendered way

Methodology: Presentation and discussion

Time: 90 minutes

Activity

Presentation

Key Features of Qualitative and Quantitative Research Approaches

Qualitative Methods	Quantitative Methods
Provides the depth of understanding	Measures prevalence (how many)
Asks 'why'	Asks 'how many', 'how often'
Studies motivation and processes (ex. what influences women's consuming IFA tablets)	Studies outcomes (ex. how many women consume IFA tablets)
It explores attitudes, behaviour and experiences through such methods as interviews or focus groups. It attempts to get in-depth opinion from participants.	It generates statistics through the use of large scale survey research, using methods such as questionnaires or structured interviews.
The contact reaches a few people but it tends to last longer.	The contact reaches many people, but it is quicker and shorter.

It often involves field observation, intensive case studies, narrative analysis and methods of constant comparison.	It is based on empirical evidence and aims to describe, explain and predict.
Tends to be more subjective; can develop theories on the basis of constant comparisons and asking of concept related questions. The researcher questions his/her own interpretations	Tends to be more objective; tool is the questionnaire. The questionnaire consists of multiple choices with pre-coded answers and also there may be few open ended questions.

(i) What is Qualitative Research (QR)?

QR a form of formative research with its own set of methods which seek to

- Understand what people think and believe; their feelings a attitudes.
- Obtain insight regarding behaviors of the target groups, including home level practices, utilization of services.
- Provide the context in which people believe and act the way they do.
- QR is useful because it is....
- Flexible - study design can be modified while in progress.
- Cost - effective, depending on the objective.
- Helps design further research; explore initial research questions.
- Valid – gives an insight into what people really believe and how they behave; data is often closer to the 'reality' compared to quick structured surveys.

(ii) Emergence of Qualitative Research

- Recent years witnessed strong pressure against the use of 'quantification' in research and the need to reconsider the utility of qualitative methods and question the superiority of quantitative methods especially when dealing with people and their lives.
- Need for qualitative research was felt due to disillusionment with quantitative research in its typical form on several accounts.

- In quantitative method, the 'Etic' i.e. outsider's perspective is dominant. In qualitative method the 'emic' i.e. insider's perspective is dominant.

(iii) Towards Successful QR

- Understand properly the objectives of the research.
- Have some level of technical understanding of the subject.
- Learn the art of asking "why", to probe effectively.
- Learn the art of Listening; it is not easy.
- Minimize subjective bias.
- Do not use QR like QN research.
- Do not judge the 'quality of QR' against 'norms set for QN research'.
- Understand and maximize the validity and reliability of the tools used, as relevant. QR is more for validity; less for reliability.
- While being careful of the process, do not be excessively worried about the techniques of the tools; modify as needed provided it meets the objectives.

(iv) Towards Gender sensitive QR

- Methods are determined by the research questions- weave gender issues and concerns into the types of information generated from the methods as well as how the method is applied.
- Consider: to whom are the questions being asked (participants: men, family members, elderly females); when is data collection taking place (suitability to the women); who is asking the questions (men or women or both; young girls, or married women); who is influencing the responses.

- Let the 'data speak' –objectively and honestly understand what the people are conveying; not superimposing your own values/concerns on people's voices.

- QR data collection; probing and searching questions -can become, not just gender insensitive; but 'human insensitive' –hence collect the data with sensitivity; let us not forget that we are invading on people's time.

- We need to reflect. How ethical is it to go on and on collecting data without using it to better people's lives.. could we at least empower them with the knowledge.

(v) Qualitative Research methods: Case studies

- A powerful type of QR, giving rich insights into people's feelings; perceptions; behaviors.
- Especially useful for gender focused research; as women or adolescent girls and the men folk give information in the context of their lives; environment; social norms.
- Can serve as an advocacy tool.

Readings

1. Attig, B.Y., Attig, G.A. Boonchalaksi, W., Richter, K. and Soonthorndhada, A. (2001). Qualitative Methods for Population and Health Research. Salaya, Thailand: Institute for Population and Social Research, Mahidol University at Salaya.
2. C. Cope, P. Van Royen & R. Baker. Qualitative Methods in Research and Health Care Quality.
3. J. Kitzinger. Qualitative Research: Introducing Focus Groups (Handout)
4. S. Knani. Key Informants Interview

Based on the session developed by Shubhada Kanani

Session 15: Secondary Data: A Useful Source in Research

Learning Objectives

Participants will

- Be introduced to sources of secondary data.
- Develop skills of interpreting large quantitative data sets from a gender perspective.
- Understand and differentiate between objective and subjective interpretation.
- Learn how to look at the data critically.

Methodology: 1. Exercise 2. Presentation 3. Small group exercise

Time: 90 minutes

Activity

Exercise 1

This exercise is designed to help participants understand and differentiate between objective and subjective indicators/ information. They are asked to look at any individual in the room, e.g. the course coordinator and asked to describe this person in one sentence. Each sentence is then analyzed to see how 'objective' and verifiable it is. It is pointed out that while it is true that a lot of situations are relative, at the same time there are situations which can also be verified using the data that has been already collected. No matter who is analyzing that data, they would be able to verify the information.

Presentation

(i) What is secondary data?

The process of gathering specific information to answer research questions is termed Data Collection. Data Collection can be primary or secondary.

- Primary data is that which is collected by the researcher to address the current research.
- Secondary data refers to data gathered by others or data from other studies. Secondary data is generally less costly and less time consuming than gathering primary data. To be able to use secondary data effectively, one needs to know its sources and the limitations of that data.
- A researcher should explore the existing data before initiating the research to understand the current knowledge/information base of the research question. So that s/he can build on the existing knowledge.
- Some important secondary data sources are official records, publications, documents, historical archives, service statistics maintained by PHCs and hospitals, etc.

(ii) In the context of population and health research

- Secondary data provides an understanding of the dynamics of population over time, particularly the changes that occur in the age-sex structure, pattern of fertility and mortality, life expectancy, morbidity condition, vulnerability of specific sub-groups (children, women, tribal) which is critical for impact assessment of existing policies and programmes and vital for future developmental planning. For example, the census data can be used to know that which sex/sub-groups over a period of time, have become more vulnerable.

- Data required for the study of population and health research are obtained through three sources-Population censuses; Registration of vital events; Sample surveys.

(iii) Salient Features of a Population Census

- Individual enumeration-Each and every person in the country is enumerated.
- Universality within a defined territory
- Simultaneity

- Defined periodicity – It is better to conduct census over a fixed period of time repeatedly to allow for comparison. The U.N. also recommends that census be done at regular intervals so that comparable information is made available in a fixed sequence. Having started in 1881 the Indian census is decadal in nature, i.e. once in every 10 years. However, in some countries census is conducted at an interval of five years.

(iv) Registration of vital events (births, deaths, marriages, divorces)

- The vital registration system, also known as civil registration, is an important tool for studying the dynamics of population.
- The complete registration and compilation of all vital events as they occur is of paramount importance otherwise information may be missed out.
- The vital registration system is almost perfect in developed countries such as the U.S., Canada, U.K., France, Sweden, Japan, Australia etc. While in developing countries like India, Pakistan, Bangladesh, Indonesia it is far from perfect. In the latter countries a sizable number of births, deaths, and marriages go unreported and hence the records remain incomplete and imperfect. This happens because of low awareness, lack of information about where to register and also because of people's reluctance to register.
- In India, the administrative machinery for the registration of vital events has been in existence for over a century.
- The analysis of the data on vital registration is done by the Office of the Registrar General, India, which publishes the data in 'Vital Statistics in India'.
- Problem of Civil Registration is that though failure to register births and deaths is punishable by law, yet coverage of vital events is far from satisfactory. There is very high rate of non-reporting of vital events particularly in the rural areas.

(v) Sample surveys

- The sample survey is another useful source of secondary data, being a large-scale survey for population studies.
- Sample survey gathers information only from a sample of the population, which is representative of the whole population/community. Conclusions are drawn using statistical methods for the whole population. Thus unlike census, it does not enumerate everyone but sample drawn is such that the data collected can be used for the entire community being surveyed.
- The sample surveys for generating population data include single & multiple round retrospective surveys.
- The 'Sample Registration System' (SRS), the 'National Sample Survey' (NSS) and 'Model Registration: A Survey of Causes of Deaths', are the three major surveys in India which provide data on population on a continuous basis.

(vi) The National Family Health Survey (NFHS)

- NFHS is the largest ever population and health survey in the country.
- NFHS was first conducted in 1992-93 and that survey is popularly known as NFHS-1.
- NFHS-2 was conducted in 1998-99 to further strengthen the demographic and health database.
- NFHS-1 and NFHS-2 obtained data through two types of survey instruments, viz., household questionnaire (to be administered to the head of the household or any other responsible member) and women's questionnaire (to be specifically administered to the currently married women). A village schedule is also used to obtain information on village level facilities like sanitation, water, education, transport and communication, health, etc.
- NFHS-1 and 2 provide state and national level estimates of fertility, mortality, infant and child mortality, family planning and health service utilization and anthropometrics measurement (height and weight-malnourishment levels) of children less than age 5 years.

- NFHS-2 additionally provides information on women's reproductive health problems, domestic violence, women's autonomy, and knowledge of HIV/AIDS, height and weight of women and children, prevalence of anemia among women and children through hemoglobin estimation, use of iodized salt at household level.
- In 2005-06 NFHS 3 was carried out in the country. In NFHS 3 interviews were taken with men also to obtain sexual and reproductive health information of men and women. NFHS-3 also tested more than 100,000 women and men for HIV.

(vii) District Level Household Survey (DLHS) under RCH project

- The first round of RCH survey (Rapid Household Survey-RCH) in India was conducted during the year 1998-99 in two phases (each phase covered half of the districts from all the states/union territories). The second round was conducted in 2002-04. RCH has interviewed both men and women in the age group of 15 to 49 years.
- The main focus of the District Level Household Survey is on the following aspects: Coverage of ANC and immunization services, proportion of safe deliveries, contraceptive prevalence rates, unmet need for family planning, awareness about RTI/STI and HIV/AIDS, utilization of government health services and the user's satisfaction.

(viii) Example of some graphs and tables and how these can be read and interpreted.

1. Population pyramid of India, Census 2001 shows reduction of fertility as the bar indicating the population in 0-4 years age group is shrinking, Elderly population is increasing as shown by the bar representing the 80+ age group.
2. Broad age structure, median age, and young and old dependency ratio by sex and residence, India 2001 young population in the country is more. Data shows that the working age population has to support both the young and the elderly; 100 working age people are supporting 75 dependent people. This implies that if there is high unemployment in

the working age population then their ability to support the dependent population will be less. In that case government's provision to support these groups would have to be more.

3. Neonatal, post neonatal, infant mortality and under-5 mortality by sex and residence, India, 1998-99. Post-neonatal mortality and under-5 mortality are higher in girls in the rural areas.
4 Percent of women married by exact age 18 years or before by current age and residence, India, 1998-99. Girls married before the age of 18 years are lesser in younger age group as compared to the higher age cohorts in 30s and 40s. Thus it may be concluded that the age at marriage of girls has been increasing.
5. Nutritional status of women, India 1998-99 Anaemia is less among pregnant women than those who are breast feeding. It could be so because iron prophylaxis is given during pregnancy and not given when breastfeeding.

Examination of demographic data from a gender perspective is critical to understand the impact of socio-cultural, economic and behavioral factors on women's health and well-being across the life cycle. Such an understanding would enable the formulation of policies and programmes which are sensitive to the needs of both women and men.

Exercise 2

The participants are given tables with data from NFHS comparing women's status and maternal/reproductive health indicators in the urban and rural areas of the two States X and Y. The participants are divided into four smaller groups.

Two groups-1 and 3 are asked to study state X and two groups-2 and 4 are asked to study state Y. The groups have to report on the following sections:

- Women's status- what can you say about how low or high it is in the State?
- Maternal and reproductive health status: what would you identify as major issues?

- Any readily observable linkages between women's status and maternal/ reproductive health status?

In each section, comment on the overall picture and also on the rural/urban differences.

Key points

- Secondary data is the data that has been already collected and documented by someone else, for example, census, human development report, report on status of women, world fertility survey.
- To be able to use secondary data effectively, one needs to know its sources and the limitations of that data.
- A researcher should explore the existing data before initiating the research to understand the current knowledge/information base of the research question so that s/he can build on the existing knowledge. When doing primary research, secondary data could be helpful as it would not be necessary to collect information that is already available. Secondary data would help in identifying gaps in research and compare with the data that is being collected.
- Some important secondary data sources are official records, publications, documents, historical archives, service statistics maintained by PHCs and hospitals, etc.
- Secondary data provides an understanding of the dynamics of population over time, particularly the changes that occur in the age-sex structure, pattern of fertility and mortality, life expectancy, morbidity condition, vulnerability of specific sub-groups (children, women, tribal) which is critical for impact assessment of existing policies and programmes and vital for future developmental planning.

Readings

1. Bhende, A.A. and Kanitkar, T. (1992). Principles of Population Studies (5th revised edition). Bombay: Himalaya Publishing House, pp. 24-29.
2. WOHTRAC. (2001, April). Integrating Qualitative and Quantitative Methods in Social Sciences. Vadodara: WOHTRAC, WSRC, Home Science Faculty, M.S. University.

Based on the session developed by Sundari Ravindran and Urvi Shah.

Session 16: Gendered Research

Learning Objectives

Participants will be able to:

- Understand the gender analysis framework/tool
- Use the gender analysis tool to critique research on a variety of health issues
- Use the gender analysis tool or framework to identify gaps and generate research questions

Methodology: 1. Presentation 2. Group Exercises and Discussion

Time: 120 minutes

Activity

1. Presentation

Gender analysis not same as sex-disaggregated analysis

- Sex disaggregated information tells whether there is any difference by sex.
- Gender analysis says that whether and how socially constructed differences in women's and men's living conditions, roles, status, behaviour and perceptions affect a specific health dimension. It analyses whether the Phenomenon being studied is affected by power relations between men and women or other differences between them. Gender analysis tells whether a condition is due to a biological cause or social difference between women and men.

- Gendered research does not mean only or necessarily collecting data for both men and women, though it might be the first step in certain researches.

Why do Gender analysis in applied health research?

- Gender differences in morbidity and mortality represent 'avoidable' and/or 'unfair' inequalities in health, unlike inequalities in health that are biological in origin. If an adverse health condition arises because of social causes it is definitely avoidable.
- Because gender is socially constructed, gender-based inequities in health are amenable to policy and programme interventions. Because society has constructed gender relations therefore society can very well change them.

Gender analysis in applied research

- Gender analysis needs to be carried out even when there are no sex differences in a specific health dimension
- Gender analysis is not restricted only to health conditions affecting both sexes, but also to sex-specific health conditions i.e. when studying conditions that effect only men or only women. For example, women dying during pregnancy because she was not taken to the hospital on time. So though it is a condition that only affects women, the problem is that they are not given proper care by others in the family.
- Gender analysis in research makes a difference to its 'what', 'how' (process of research, is data collection done), 'who' (who does the research) and 'where' and 'when' is the research done.

Gender analysis in applied health research

Is the health dimension under study likely to be different for women and men because of gender differences in?

- Division of labour and activities, physical spaces occupied
- Valuation of males and females in a given society, self esteem and behaviour patterns
- Norms about male and female behaviour (especially socially sanctioned codes of sexual and reproductive behaviour)
- Access to and control over resources
- Decision-making power

Engendering research would also examine issues like

- Workload of women
- Experience of domestic violence
- Inadequate intake of nutritious food
- Whether the pregnancy was wanted or planned
- Sex composition of previous children

How can gender analysis in applied health research be done?

- Literature review to include information from key people in the community or population under study - Gender may influence certain health dimensions in context specific ways. Therefore going only by published material may not help; the researcher may have to do some formative research, some interviews or observation. For example, in a study on nutritional status the actual situation may be that girls are not going to school where nutrition is being given. So boys have better nutrition than girls. Thus variables chosen initially for research would have to be modified on the basis of this finding from the formative research.
- The variables chosen may have to be modified for example, Change from just male/female to urban/rural male /female as per need.
- Sample size will need to be large enough to permit analysis of gender differences in sub-categories
- Integrate qualitative methods at different stages of the study
- Gender is likely to influence informed consent procedures. Also, participation in the study may affect women and men differently.
- Women may be more affected than men by participating in the research. For example, in a study assessing people's perceptions/ knowledge about STIs, women participating in the research may be perceived to be having STIs and may therefore be discriminated / mistreated. Therefore the researcher has to think whether s/he is doing well to the respondents or harm.

Gender analysis in applied health research - Who?

- Both sexes need to be represented in the study sample unless the topic is sex-specific.
- Gender considerations may influence recruitment and drop out rates among men and women differently. In the initial sample itself it is important to think about drop-outs. In some studies more men may drop-out, for example, if the time of data collection is such that midway men migrate for work purposes.
- Gender (among other variables) will influence the reliability of proxy reporting. For example, asking the male head of the household whether the woman had any reproductive health problem may not be useful as he may not know about it; similarly for information about children's health. So who does one talk to and for what kind of information, is crucial. Therefore it would be advisable to have people of both sexes in the research team.
- Both sexes need to be represented, not only among field investigators, but also among other researchers.

Gender analysis in applied health research - When and Where?

- The timing of data collection will have to take gender roles into consideration. When are men more likely to be available? When will they be able to speak at leisure? Similarly for women.
- The place most appropriate for data collection may be different for women and men, for example, in terms of safety, convenience, comfort levels.

The costs of not doing gender analysis in health research are

- Failure to assess health risks for different sub groups, resulting in avoidable mortality, morbidity and disability.
- Possible delays in diagnosis or inappropriate treatment for certain disorders. It may be mistake to assume that men and women would have acquired the infection in the same way. For example, Men would have got the STI by extra-marital sex while women might have got it

from their husbands. So accordingly interventions would have to be planned.

- The implementation of health programmes and services which do not address the major factors associated with a health problem, or meet population health needs, resulting in wasted expenditures.

Gender Analysis frameworks

- Examine first the differences in biological vulnerabilities, susceptibilities, prevalence, outcomes.
- Examine the various gender factors: social beliefs, gender norms, roles, access to resources, bargaining power in the causality, treatment seeking, consequences of the health issue being studied. Examine how the biological and the social and gender factors interact.
- How are the health systems reinforcing/perpetuating the gender inequities in health?
- What about macro factors – like the market, national and global policies? (Refer here to the multi level framework discussed in the session on Social Determinants of Health)

2. Exercise

The participants are divided into three groups. Each group is given a research study to examine the application of gender analysis to research in reproductive health. Each group has to find out how gender issues have been addressed in:

- Framing the research questions
- Constructing the study tools
- Methodology
- Analysis and discussion of results

The groups are also asked to mention if they will explore any additional research questions in studying the same issue. The group members are asked to prepare a brief group report for presentation the next morning.

After the presentations and discussion, the facilitator concludes with the following points

- Creative adaptation of the gender analysis framework by the researcher show that certain standard tools and frameworks are just beginning points and can be modified to suit the specific purpose of one's study.
- Including gender at each step of the research study is a difficult task.
- If it is included in the research questions then it will reflect at all other stages as well.
- Inclusion of gender perspective has to be done consciously done at each step, especially in the tools. If the tools did not have the gender dimension then gender will get lost from the entire study. Then the data collection using a gender sensitive tool has to analyze so as to pull out its gender dimension.

Readings

1. Verheij, R.A. 1996. *Explaining Urban-Rural Variations in Health: A Review of Interactions between Individual and Environment*. Social Science and Medicine. 42 (6), pp. 923-935.
2. Gupta, J.A. May 1993. *'People like you never agree to get it: an Indian family planning clinic*. Reproductive Health Matters, 1, pp. 39-43.
3. Pendse, V. 2001. *Maternal Deaths in an Indian Hospital: A decade of no change?* Reproductive Health Matters. Special Supplement on Safe Motherhood Initiatives, Critical issues, pp. 119-126.

Based on the session developed by Sundari Ravindran and Abhijit Das.

Session 17: Gendered Indicators

Learning Objectives

The participants will be able to:

- Understand what indicators are
- Describe why indicators are needed
- Identify and develop gendered health indicators

Methodology: 1. Quiz on some indicators 2. Presentation 3. Small group exercise

Time: 90 minutes

Activity

1. Quiz

Participants are divided into two groups. Chits with indicators written on them are kept in a bowl. Each group has to pick up a chit alternatively and give a precise definition of that indicator.

- Infant Mortality Rate
- Fertility Rate in age group 15 – 19 years
- Maternal Mortality Ratio
- Literacy Rate
- Net Primary Enrollment Rate
- Contraceptive Prevalence Rate
- Doctor-Population Ratio
- Percentage of births attended by skilled attendants

Each indicator is discussed in detail. The importance of the clarity and consistency in the denominators is very important. It is also important to know how the indicators have defined in a study. The researcher may use one particular definition while the reader may understand it differently.

2. Presentation 'Engendering Indicators'

What is an indicator?

- An indicator is a pointer. It can be a measurement, a number, a fact, an opinion or a perception that points at a specific situation or condition, and measures changes in that condition or situation over time. Indicators provide a close look at the results of initiatives and actions (CIDA, 1997). There are input, process and output indicators. These types of indicators are contextual and may change form study to study. What may be input indicators in one study may become process indicators in the other and like wise.

Sex disaggregated v/s. gender sensitive indicators

- The two are often used interchangeably, but are in fact not the same.
- Sex disaggregated information tells us whether there is a difference by sex in a specific dimension of health. Gender sensitive indicators are meant to help us understand whether the problem or the sex differential is influenced by gender inequality. One can have gendered indicators even where separate data is not being collected for males and females.

Indicators for assessing gender equity in health programmes

- 'Gender sensitive' indicators are needed in routine data collection in health, to:

    - identify the existence of a problem i.e., are there differences in male and female health that cannot be random?

    - gain some insight into whether gender role socialisation or discrimination underlies the cause of the problem.

- The above can help develop interventions to address the problem.

- The same indicators can then be used to assess whether the intervention has brought about the desired impact.

How can indicators be 'gendered'?

- New indicators on those dimensions of health where gender differentials occur (or are likely to occur) most often need to be brought into use.

  Example:

  - Indicators on social and economic consequences of STIs or infertility for women as compared to men
  - to ask not only whether medical help was sought but also what kind of medical help was sought because many studies show that women tend to use providers closer to home or who are less expensive, and this is because of gender factors

- Additional variables, across which data on the indicator would be disaggregated, need to be included. Choice of variable based on analysis of gender factors likely to impact on the health dimension. Example: MMR analysed by place of death (home or health facility?); cause of death analysed by type of attendance at delivery.
- Analysis or re-analysis of existing data-sets across 'gender' factors Example : - Demographic and health surveys provide information on non- use of antenatal care or non-use of contraception, and also on reasons for non-use. Some of the reasons asked are: husband does not permit, women does not think it is necessary, she cannot afford; the two can be cross-tabulated to see what proportion are not using for what reason for example, Unmet need not only because of unavailability but because of gender factors.

  - There is also data on whether the last pregnancy was 'intended' and separately, on experience of domestic violence. Cross-tabulating the two would expose if the two are related.

- Developing new indicators to be used concurrently with others already in use, based on the same sources of information

  Examples - Indicator: Proportion of pregnant women who are seropositive for syphilis

  Modified indicator: Of pregnant women who are syphilis seropositive, proportion who report that their partners have symptoms

  - Indicator: Proportion of women below 19 years who have had a child or been pregnant. Usually only woman's age is taken. If father's age is taken then one may be able to get gendered reasons behind teenage pregnancy, very early pregnancy, perhaps incest therefore, the following modified indicator can be used.

  Modified indicator: Proportion of the above who report the age of the child's father to be 30 years or more

Indicators for assessing gender-sensitivity of health facilities

- Do service timings take into account gender differences in relation to work schedules? For example, immunisation on Monday, ANC clinic on Wednesday-it may be difficult for women to come on separate days for routine services.
- Are services organised and delivered in such a way that they recognise how gender norms affect women's ability to seek health care and complete treatment?
- Are services priced in such a way that they consider gender differences in ability to pay the costs (transport, official and unofficial fees)? Are prescriptions made with this awareness?
- Do service practices take into account the consequences of women's lack of power for their health problems and their ability to comply with advice and treatment? For example, is the woman told things like 'do

not get pregnant again', 'why are you coming again and again with pregnancy, you are supposed to use contraceptive'. Is the health facility taking into consideration gender relations effecting reproductive health?

Developing and using appropriate indicators is a means, not the end

- Indicators are only a tool to assess whether there is a problem, and whether one is moving in the right direction towards addressing these problem
- Unless acted upon, they remain useless. Collecting data is not enough; problem would not be solved unless action is taken on the data/indicators collected.

3. Small group exercise - 'Developing gendered indicators'

The participants are divided into four groups. Each group is given a project on a Reproductive Health issue. The groups are asked to modify the given indicators so that the new set of indicators addressed gender/rights dimension of the problem.

Group 1 - Adolescent (and young people) reproductive health project

A new project for the improvement of the reproductive health of adolescents is being initiated in your district. The project is planned for a three-year period. The objectives are:

- To promote condom use
- To prevent unsafe abortion
- To promote postponement of childbearing

The following are some indicators routinely used for monitoring this project:

- Proportion of (sexually active) adolescent boys reporting condom use (this may be further refined, for example to specify regularity of condom

use, access to condoms, or whether a condom was used in their most recent sexual encounter).

- 15-19 year olds as a proportion of all abortion related obstetric and gynecology admissions.
- Proportion of women in the 15-19 age groups who have had one or more children or are currently pregnant.

Group 2 - Safe motherhood project

Concern has been raised about the number of maternal deaths reported in your area. A safe motherhood project aimed at reducing maternal deaths over the next three years is to be implemented very soon. The specific objectives are:

- To prevent delay between the development of a serious complication in pregnancy and reaching a health facility providing emergency obstetric care.
- To prevent delay within health facilities in initiating appropriate treatment.

The following are some indicators routinely used for monitoring this project:

- Proportion of women who died at home or on their way to the hospital.
- Percentage distribution of maternal deaths in hospital, by time between admission and death.
- Proportion of women reporting a delivery complication who delivered in a health facility.

Group 3 - Improving the quality of family planning services

In your province, more than 80% of contraceptive users have adopted female sterilization. Your brief is to improve the quality of family planning services offered in the five primary health centers under your supervision over the next three years. You design a project which aims to:

- Widen contraceptive choice for women and men

- Improve follow-up services
- Improve client satisfaction

The following are some indicators routinely used for monitoring this project:

- Percentage distribution of all contraceptive users, by method used.
- Proportion of contraceptive users reporting at least one follow-up contact with the health facility or health worker.
- Proportion of satisfied users at the end of x months following acceptance.

Group 4 - Prevention and control of RTIs/STDs

A new RTI/STD prevention and control project is being implanted in your health facility. The objectives of the project are to:

- Improve awareness of the signs and symptoms of RTIs/STDs.
- Promote treatment seeking among those with symptoms of RTIs/STDs.
- Encourage partner notification and treatment.

The following are some indicators routinely used for monitoring this project:

- Proportion of clinic users who are aware of the symptoms of one or more RTIs/STDs.
- Number (and/or proportion) of clients seeking treatment for RTIs/STDs.
- Proportion of clients (by sex) whose partners have also sought treatment.

Possible responses of Gendered Indicators

Group 1 Young people's Reproductive Health project

New indicators for safe abortion

- Proportion of girls who know about facilities that provide safe abortion.
- Proportion of girls who get safe abortion services.
- Proportion of partners accompanying women for abortion.

- Of the abortion related admissions in OBGY department how many are second trimester abortions in adolescents/young people. This would be due to some gendered reason. Look at the gender dimension of postponement.

New indicators to measure success in postponing pregnancy

- Proportion of adolescents who can communicate with their families about postponing pregnancy.
- Number of women who report discussing condom usage with their male partners in last one month divided by total number of women, could help assess whether negotiation between partners has changed.
- Proportion of girls who say that their partners used condom.

Group 2 - Safe Motherhood Project

There is need to capture whether the woman had the decision- making power or not. Therefore to see whether any gender related cause was responsible for delay the indicator could be the:

- Percentage of women who were referred to the health center but did not go. But reason for not going may be poverty. So another dimension would have to be added to get a gender sensitive indicator like socio-economic indicator.
- Proportion of husbands/decision makers aware of complications.
- Proportion of husbands/decision makers accompanying the wife to the health centre (this is important because if the decision makers do not accompany then treatment may not start even after reaching the hospital due to lack of money or consent to do an operation, blood transfusion, etc.).
- Proportion aware of where to go in case of complication.
- Whether the attending doctor is a male or female.

Group 3 - Improving the quality of family planning services

- Percentage distribution of all contraceptive users, by method used for both men and women separately.
- Awareness of various contraceptives available for both men and women.
- Number of contraceptive users divided by the number of people who would prefer to use a certain method as their first choice but could not use it for some reason. For example the husband did not want to use condom, so the woman was compelled to take pills.
- Availability and accessibility- 'number not using contraception because of cost divided by number not using contraception' would tell whether cost was a deciding factor.

Group 4 - Prevention and control of RTIs/STDs

Additional indicators

- Number of people suffering from RTI/STD and those aware of the same.
- Number of clinic users divided by total population suffering from RTIs/STDs (A prevalence study would have to be done to calculate the indicator).
- For the third objective also an indicator can be added-Attitude of uninfected partner towards infected partner. This would need to be broken down further to measure attitude as attitude is a 'subjective' indicator.

Segregating data for the two sexes in each of the above indicators would give gendered indicators.

Often RTIs in women are asymptomatic. Therefore awareness among men and women about asymptomatic RTIs in women would be useful. If men are not aware that wives may be infected without symptoms then it may be difficult for women to seek treatment.

Key points

1. An indicator is a pointer. It can be a measurement, a number, a fact, an opinion or a perception that points at a specific situation or condition, and measures changes in that condition or situation over time. An indicator is a numerical value representing broad social reality somewhere else. Any kind of marker in a situation is an indicator. Indicators are useful for comparisons, for understanding change; they are the references for reality.
2. The role of an indicator is to make complex systems understandable or perceptible. An effective indicator or set of indicators helps a community determine where it is, where it is going, and how far it is from chosen goals. Indicators of sustainability examine a community's long-term viability based on the degree to which it's economic, environmental, and social systems are efficient and integrated.
3. Usually indicators are expressed in numbers, eg: number of participants in a program, the proportion of which are male or female, or from different age groups or ethnic groups, or geographical areas, % of clients satisfied with the information provided or % of people who have stopped smoking.
4. It would be better to have as few indicators as possible, both for data collection and analysis. Though one may begin with a lot of indicators, it was always better to narrow down to a few indicators to make it easier and manageable.
5. The indicators could first be calculated when the project starts and then after one year so that the progress of project could be evaluated.

Based on the session developed by Renu Khanna and Abhijit Das

Session 18: Gendered Study Designs

Learning Objectives

The participants will be able to:

- Know what are the various research designs
- Develop skills to plan suitable research designs using either or both quantitative and qualitative methods

Methodology: 1. Presentation 2. Group exercises and discussion

Time: 90 minutes

Activity

1. **Presentation**

Difference between action researches, intervention, operations research, needs assessment.

While doing 'Action Research', one makes an intervention. A baseline may be done, then intervention made, and then the change may be assessed. The whole process may be documented along with the outcomes. Such intervention researches are also called experimental intervention studies. An intervention research could be an action research, but an action research need not be an intervention research.

In 'Operations Research', the process is not documented in such detail. It involves: baseline, intervention and then end line.

Needs assessment is an open enquiry. Here the domain is not academic, rather it has practical orientation.

Quantitative Studies

Cross-sectional studies are studies which compare characteristics among different age groups at one time.

Longitudinal studies involve observations of the same items over long periods of time, often many decades. Longitudinal studies are often used in psychology to study developmental trends across the life span.

Cohort studies are part of longitudinal studies, done with the same population over a period of time. These studies can have drop outs but can not have new add ons.

Surveillances: Surveillance is the monitoring of behavior, studying the behavior to track the pattern in a sample from the same population every year.

Qualitative studies

Exploratory studies: In these studies, one does not begin with a theory. Instead, the data collected, after analysis, is used to develop a theory. One might then design a study to test the theory.

Descriptive studies: these studies describe phenomena systematically to reveal patterns and connections that might otherwise go unnoticed. Descriptive studies include normative, epidemiological, correlation, and on-intervention case studies.

Group Exercise

The participants are given a situation and asked to discuss the study design for it: *'In a large tertiary obstetric service, the health professionals suspect that the number of newborns of very low birth weight (LBW) is increasing. The service wants to know if this is true, and if so to have a*

better understanding of the social and economic situation of the women who are delivering low birth weight babies.'

Research questions

- What was the proportion of very LBW new born babies in March 2003?
- What is the proportion of very LBW newborn babies in March 2006?
- Is giving birth to very LBW babies associated with women's
  a. education levels b. caste c. economic status

Definitions of the terms

- Very LBW: Less than or equal to 1500 g.
- Indicators of socio-economic status: the indicators could be 'years of completed schooling', economic indicators to judge whether people are living in poverty and what is the extent of poverty. The most significant indicator of poverty would have to be used. For example, a fishing community would need things like boat and nets for their livelihood. If the respondent does not even own a net, then the family could be classified as being very poor.

Evidence needed to answer the research questions

Number of live babies born and their weights would be needed to classify them as very LBW and not very LBW.

Preliminary analysis could tell whether the proportion of very low birth weight babies has increased. If the proportion is found not to have increased, then there is no need to move further. But if a seasonal variation is found then one has to consider the research question 'why is there high proportion of very LBW babies in those months'.

Secondly if a change in proportion is found but patients' socio-economic information is not available then primary data collection may have to be done. Primary data would need to be collected like 'nature

of delivery- normal/caesarean', 'birth weight', and 2-3 indicators, like those mentioned above for SE status.

Further analysis could be done on 'What are the causes of very LBW babies?'

Proportionate weight gain by the mother or weight gain adequate during pregnancy - Yes / No

- Whether the woman has been given necessary ante-natal treatment for- anemia, blood pressure etc.
- Presence of sexually transmitted infection, heart disease, tuberculosis

Thus a combination of demographic, social, economic, gender indicators would have to be developed.

Sample size

Mothers of both very LBW babies and not very LBW babies would be part of the sample in order to compare.

Study design

Some of the quantitative study designs related to the concerned study.

- Descriptive study: To begin with, data of all the deliveries occurring in the hospital is collected and compared. Suppose one finds that of the total 100 women who delivered, 80 women gave birth to normal birth weight babies and 20 to very LBW. Further it is found that of the 20 women, 18 are illiterate while of the 80 only 17 are illiterate. Thus one observes a higher proportion of illiterate mothers in the group who delivered very LBW babies. It could therefore be concluded that there is some association between literacy levels of the mothers and birth weight of the newborn babies.

- Case control study: It starts after the event has occurred. For example very LBW babies are already born and then their characteristics are studied. Very LBW babies are matched with normal babies. A third category could also be included, babies with birth weight ranging from 1500g to 2500g. Then one would compare the difference between the three groups of mothers. These women are called 'cases' and then 'controls' are chosen.

- Cohort study: It is usually prospective, that is, it would start now and go into the future. One group has the risk factor and one does not have the risk factor (tobacco chewing, poverty, smoking etc.). For instance one group of women is tobacco chewers and the other group is non chewers. The outcome of the two groups of women is compared.

There is an ethical issue in such a study. If the researcher knows that tobacco chewing would harm the child in the womb then should the researcher intervene during pregnancy period to reduce harm to the child? The intervention would influence the study result.

- Intervention study: Suppose the hospital has found out that socio economic status effects the birth weight of the new-born babies and wants to do an intervention. So, baseline is done and then an intervention is done in which women are registered on a feeding programme. Then an end line survey is done. Another way of doing it could be to do baseline surveys in this hospital and in another hospital which would not have an intervention programme. After doing the intervention in one hospital, end line studies are done in both of them.
- There are problems with each of the two study designs. A better design would be one in which women in the same hospital are randomly included or not included in the feeding programme. For example, each woman is given a token-either red or green. Women with red token go to the feeding programme while women with green token do not go. But this too has ethical problem as both would have benefited from the

feeding programme, so why deprive one group. Therefore it is not ethical to do such a study.

- Cross sectional study: Such a study talks of situations at a point in time. For example it would say that at present a certain group of children are well nourished and another group is malnourished. It would not tell that how did the children reach in either of the groups.
- Trends: Trends say how the situation last year was and how is it this year. It gives the pathway, and does not say what the situation at this point of time is.

One could do comparisons within qualitative framework also. One could get associations based on gender variables and then the reasons/ 'why' could be found through the qualitative study.

Gender related variables

- Workload during pregnancy
- Faced violence during pregnancy
- Whether facing lack of partner's support/regard from husband
- Food intake less because of being a woman
- Lack of medical care due to her being a woman
- Access to and control over resources
- Whether the woman neglected herself during pregnancy because she did not want the pregnancy as she suspected the fetus to be female.

Readings

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Based on the session is developed by Sundari Ravindran and Abhijit Das.

Session 19: Developing Gender Sensitive Data Collection Tools

Learning Objectives

The participants will be able to:

- Develop a study tools on the basis of the research questions

Methodology: 1. Exercise on Questions 2. Group exercise to develop tools and discussion

Time: 180 minutes

Activity

1. *Exercise*

The facilitator presents ten questions to the participants and asks them to improve upon the questions.

Sr. No.	Question	Participants' possible responses & discussion
1.	Were you satisfied with the cleanliness and privacy in the health centre?	Talks of two aspects-cleanliness and privacy. If answer is 'yes', researcher will not know what the person has answered 'yes' to. So it can be divided into two questions. Besides it has to be specified that cleanliness of what is being talked about. Similarly referring to visual or audio privacy- the person may be in a separate room (visual privacy) but others outside could listen, would it be privacy? Also it is a leading question, 'were you satisfied...', so it should be 'What is your opinion about...'.
2.	What brand of computer do	First it has to be asked that 'Do you own a

	you own? a) IBM PC b) Apple	computer?' There could be a third option in the response-'any other, please specify'. This should be asked only if really needed as often this part is not analysed later.
3.	What cooking fuel do you use? a) Wood b) Kerosene c) Gas	Combinations are missing, there can be multiple answers. So, instruction could be 'Tick all that you are using'. There should be an option 'any other'. It can also be made a ranking question. Thus depending on the study objectives, options may be given.
4.	Mark the age group to which your child belongs: a) 0-1 year b) 1-2 years c) 2-5 years	Overlapping, if child is 1 year old, where would the person mark-in a or b? Option of 'above 5 years' is missing. For which child is the question being asked, if respondent has more than one child. 'Zero' is not understood by many, so first option could be 'less than 1 year'.
5.	Are you against sexual abuse? (circle Yes or No)	Sexual abuse has not been defined; It is a leading question.
6.	Are you satisfied with your current health insurance? (circle Yes or No)	Person may not have health insurance; 'Satisfied' is subjective.
7.	What percent of your budget do you spend on food?	What is 'food'? It may mean different for different people-milk, fruits, snacks may or may not be considered as food. But the basic problem is that most people would not know what percentage of their income is spent on food. House rent may be

		known as it is paid in bulk, but not food. If one is staying in hostel and paying fees, then it could be answered. If one says 'average' in response, then is it the average of lean month or better-off month? Question is not asked about a specific period. Many people buy certain cereals, pulses, etc in bulk for a year. This question is not a useful question to ask.
8.	Are you in favour of the 2004 amendment to the MTP Act?	Respondents may not know what is MTP Act and the amendment to it. So when everyone answers 'No', the researcher would wrongly conclude that all these people are not bothered about such issues.
9.	Do you think the two-child norm is violating people's rights?	What is 'two-child norm'? Who are the 'people' here? 'Rights' may be understood differently by the respondents.
10.	Do you exercise regularly?	What is 'exercise', 'regular' (once a month could also be regular)?

Participants learn how questions should be framed through the above exercise.

2. Group exercise

Participants are divided into three small groups. Each group is asked to design a research tool according to the following situation:

"You are about to introduce a new counseling service for men in your STD clinics, which focuses on preventive behaviour, especially the use of condom.

This is a pilot project. The new service has cost a lot, and in order to justify its expenses you will need evidence demonstrating whether the new service has any positive health impact. Design a tool to evaluate the service assuming baseline data for the period before the service started is available."

Group 1 - Design a Focus Group Discussion Guide

Some tips....

- The tool should ensure that the pattern of communication is not question-answer between the facilitator and the respondents. Instead in a FGD one member says something, then another says something else, newer questions emerge from the group and the discussion moves on. Criss-cross, unplanned and unexpected responses are the value of FGD.
- In a FGD questions should not be as though one is doing a group interview. Questions asking opinions, perceptions, beliefs, where respondents can provide normative, general patterns are to be asked.
- Nature of questions in the FGD should not be leading, for example, "Are you satisfied...?", instead they should be probing.
- Terminology such as asking for "...correct usage..." may elicit expected answers. Thus it is better to ask "What are some difficulties in using condom", "How is a condom used?"
- Projective techniques could be used. For example, "There is a man, Ram who has received counseling but does not use condom, and there is a man, Shyam who has received counseling and uses condom. What do you think could be the reason for the difference between Ram and Shyam?"

Group 2 - Develop an Interview Guide

The interview guide is prepared for three groups of people: Counseled and using condom; not counseled but using condom; counseled but not using condom. Questions at the end cover the third group.

- Personal profile: Age, occupation, completed years of schooling, marital status, years of marriage, partner preference, family size, income.

- Awareness and knowledge about STDs

  - Knowledge about symptoms, causes and preventive measures.
  - Source of information.
  - Gender differences in the prevalence.
  - Sources of treatment-Public/private/traditional/informal.
  - Ideas about particular sexual acts leading to STDs.

- Contraceptive practices

  - Information about available contraceptive methods.
  - Condom- preferred as a preventive method.
  - Proper use of condom.
  - Consistent use of condom.

- Counseling

  - Counseled or not.
  - Views about counseling- how useful are it for the respondent, if using condom then what factors influence its use. If inconsistent use, then why is it so.
  - Factors other than counseling influencing condom use like social marketing.
  - Relationship between counseling and condom use.

Facilitator's Feedback and Discussion

Guide is well thought out and systematically done.

- You need to be more precise in an in-depth interview. Stick to the main focus which is about men's existing knowledge and how counseling has influenced it.

- You can explore if there are any norms about gender influencing condom usage- for example, the respondents use condom only with sex workers and not with wives or their regular partners wife might not insist on condom use as it could be taken as an indication of sex outside of marriage by husband; any gender issues/marital factors/ notions about masculinity affect condom usage.
- There is no point asking questions related to gender if gender issues have not been discussed in the counseling.
- Asking about contraception is irrelevant here as the focus is condom use and most of them are condom users. So one should rather find out how regularly do they use condom and from where do they get them.
- Since the research problem is "Has counseling influenced condom use", there is no need to ask about STDs even if counseling covered this.

Group 3 - Structural Interview through a Questionnaire

Since the research problem is, "Has counseling influenced condom use", it might be difficult to have the same respondents back in the health centre for post-counseling interview as for pre-counseling interview. Therefore the group states that they would do the interviews in the community. It is an operational design, experimental/control design with an intervention area and a control area. Other NGOs might be working in the control area on the same issue due to which there might be increase in condom use. But such an increase in rate of condom use might not be as much as in the intervention area. Thus it might be possible to conclude that counseling had made a difference in the intervention area.

The sample that the group chooses is 18-45 years old men. The interview schedule is divided into four sections.

Section I- Identification of respondent **ID No. ----**

1. Which is your place of residence
   a. Intervention area
   b. Control area
2. How old are you? _____
3. Number of schooling years completed _____
4. What kind of work are you currently engaged in? _____
5. What is your family income? _____

Section II- Clinical information

6. Are you currently suffering from any of the following problems- abdominal pain, pain in groin area, white discharge from penis, scrotal swelling, genital ulcer, burning sensation during urination?
   a. Yes b. No

Section III- Condom use

7. How often are you involved in coitus?
   a. Never b. Rarely c. Often d. Always
8. How often do you use condom?
   a. Never b. Rarely c. Often d. Always

Section IV- Counseling

9. Has anybody discussed with you the importance of using condom?
   a. Yes b. No
10. Has anybody demonstrated condom use to you?
    a. Yes b. No
11. Has anybody informed you about the places where you can get a condom?
    a. Yes b. No
12. Additional question for post-intervention interview (the above is common to pre and post intervention interview)

- During the last six months, have you heard/seen/read any information on condom use through the following means:

a. Radio (Y/N)

b. Inter-personal, other than counselor (Y/ N)

c. Télévision (Y/N)

d. Newspaper/magazines (Y/N)

e. Mass information (Y/N)

The group members explain that they asked about family income to know whether the respondent belongs to low/middle/high class though they are aware it might be difficult to ascertain. They further explain the frequency classification used in the schedule- 'Never' implies 'never used so far', 'Rarely' refers to 'once in a while', 'Often' means 'more frequent than once in a while', 'Always' implies 'each time'. They say that to address the gender issue they would add a question- "Does your wife/ partner like or has any objection in using condom?" The group also clarify that Section IV is to determine the efficacy of counseling. Since the respondents might not understand it directly, therefore three questions are included to get this information.

Facilitator's feedback and discussion

- Interview schedule is quite comprehensive; it should not miss out on respondent's ID No. Questions are clearly numbered – this is important in a structured interview schedule.
- You do not explain how will you will get control and intervention groups.
- How is the family income relevant? The group responds that they want to see whether income is related to access to counseling as well as access to condom. By classifying into three groups-low, middle, high- we might be able to pin-point which income groups are coming for counseling and which are not, so intervention could be planned accordingly.
- With respect to the frequency classification, if the respondent has sex twice a week and uses condom once a week, then in which category

would you put this? -'rarely' or 'often'? So the category is concluded to be ambiguous.

- The language of questions 9, 10 and 11 is centered on the person. It can be "Has .....been discussed with you?"; "Have you been informed about....."
- The respondent might have got the information from counseling as well as other mass media sources. How would you ascertain what actually influenced condom use?
- The respondents could be asked to classify themselves as low/ middle/ high income and this method has been used effectively.
- Why do we need to ask how many times does the person engage in coitus. Instead one can ask "Out of the number of times you have coitus how often do you use condom" with options given as- 'never, more than half the time, less than half the time, half the time always '. The response 'never had sex' could be included as the opening question in the section, for example "Have you had sex in the last .....Period?" Alternatively "How often do you use condom: never needed (did not have sex), used every time, some times (about more than half of the time), less than half the time, never despite having sex" or put in percentages- 25 to 50%, 50 to75% etc.
- Though the schedule is quite comprehensive, some essential questions are missing. The post intervention schedule should have specific questions to assess the effectiveness of counseling, specially, knowledge that they would have gained from counseling, for example "Condom is used for....."
- There are no questions on availability of condom. Respondents might say that they are not using condom, from which the researcher might conclude that counseling is not effective. But actually condoms may not be available. So availability and affordability questions have to be included in post intervention interview schedule.

The facilitator concludes the session by saying that it is always better to show the instrument that one prepares, to as many people as possible even before

piloting. Researcher should not be defensive about it and rather take the opinion of others as each new set of eyes gives new insights.

Key points

1. One has to be very clear about the rationale of the enquiry, that is, why are we doing the particular research.
2. One must take into consideration the concept of insider and outsider perspective i.e. emic and etic perspectives.
3. One needs to be conscious about the use of words and should operationalize every term used in the research.
4. Participatory action research is also an option for such issues where one involves community to research on their own issues.
5. Gendered research does not mean only or necessarily collecting data for both men and women, though it might be the first step in certain researches. Sex segregated information would give the data for both separately. But how would research on a condition that affects only women or men be gendered?

Readings

1. Boynton, P. M. and Greenhalgh, T. (2004). Selecting, Designing and Developing your Questionnaire.
2. Design of Interview Schedules. General Considerations (Handout) dcc2.burnc.bu.edu/prdu/INRUD_2000_CDROM/Manuals/Qualitative_Methods_Manual/ qm _and.doc
3. Britten, N. (1995). Qualitative Research: Qualitative Interviews in Medical Research, Education and Debate. (Handout).
4. Mays, N. (1995). Qualitative Research: Observational Methods in Health Care Settings. Education and Debate.
5. Lingam, L. (2004). The Stranger with a Shoulder Bag. In M. Pawar (Ed.), Data Collecting Methods and Experiences: A Guide for Social Researchers. New Delhi: New Dawn Press, 133-141

Based on the session developed by Sundari Ravindran and Abhijit Das

Session 20: Analyzing Qualitative Data

Learning Objectives

Participants will be able to:

- State basic principles of analyzing qualitative data
- Recognize/identify common problems in qualitative analysis

Methodology: 1. Presentation 2. Exercise

Time: 60 minutes

Activity

1. **Presentation**

Features of qualitative research

- Data collection through close proximity
- Provides "thick descriptions"
- Data collected over a sustained period of time
- Higher possibly of understanding the underlying issues

Data Analysis

- Descriptive explanation involves the construction of an explanatory model of what is going on in a particular social location, or of operationalizing a set of social processes (Mason, 1996).
- Micro analysis involves careful, minute examination and interpretation of data. It is necessary to generate initial categories and to suggest relationship among categories (Mason, 1996).
- Gender analysis helps to identify gender differences and patterns concerning specific issues. It also provides guidelines for examining the important social, cultural and economic factors that affect an individual (DFID, 1999).

Steps in analysing qualitative data

- **Data treatment** ⟶ **Data Reduction**
- **Data reduction**: Reduce the data from all that has been collected so as to make it manageable. Data reduction refers to the process of selecting (the useful information on the basis of objectives, research questions, conceptual framework), focusing, simplifying, abstracting and transforming the data in the field notes or transcription in such a way that final conclusions can be drawn and verified.
- **Formulation of categories and codes**: One could have pre-formulated categories depending on the conceptual framework and these could be modified later after data collection.
- **Memoing**: While reading field notes, the researcher might have ideas of how to analyze; some associations might begin to form. Memo is the process of writing down those analytical ideas as one reads the field notes. For example, while reading her notes the presenter found association between the importance of parenthood and gender.

Before beginning the process of coding, field notes are to be re-written in an expanded form to make them reader friendly and more analytical.

The resource person shares her experience of conducting research on 'Involuntary childlessness among the middle class in Vadodara city'. (This study is one of the three studies used in Session 13 on 'Gendered Research' of the course.)

Coding styles

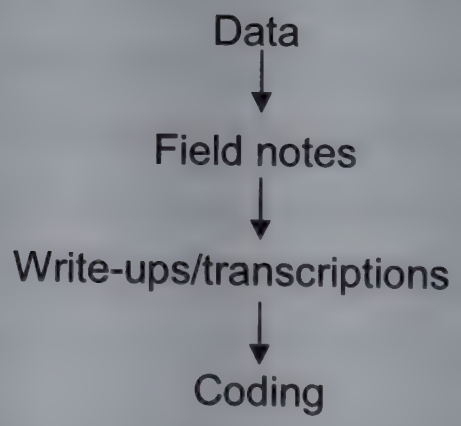
- **Open coding** - Data is broken down into discrete parts and closely examined and compared for similarities and differences. Subsequently, similar events related in meanings are grouped together under the same categories (Strauss & Corbin, 1990). This is the first level of coding.

Example: Narrative from the presenter's research-"My mother would say your sisters are waiting, even as a usual Indian saas, my mother is also thinking that by now she should have had a child, but now we have told them that Anita is having some problem, I was also having some problem. So now they say, let us pray to God and you will get the result. But of course 80% people *kem na thayu atyar sudhi ma*, till the time we told them that *aa* problem *che to war lage, jyare thai tyare thai." Open coding given by the presenter-* Societal attitude, Coping behaviours, Family reaction.

- **Axial coding** - Data is reassembled. Categories are related to the subcategories to form precise and complete explanations about phenomenon (Strauss & Corbin, 1990). This is the second level of coding.

  Example: Narrative for category 'Coping behaviour'- "We know how you put it across to them and how you take it."

- **Selective coding** - Categories are revisited for integration and refinement. If the researcher has pre-formulated categories then this last level of coding would take less time.



Data reduction charts

- Responses of all the participants are put in data reduction charts to ease the process of data display.
- The Refine the initial categories for data display process.

- Some of the domains used by the resource person for data reduction are self, spouse, family, society.

2. Exercise: 1

The resource person gives excerpts from the interviews of her research and asks participants to mark the gender norms and gender roles that they found in those excerpts.

Gender norms/roles as identified by the group:

- Medical treatment and gender- In one of the excerpts the bias of the medical professionals comes out very clearly. Even though the couples are being treated for infertility for the last 5-6 months, the husband is not asked to get any investigations done. It is only later that he has asked to do so; initially the treatment is for the woman.
- Men's gender roles: male respondent could not take leave from work (men's role as provider of the family) to be with his wife while she was undergoing treatment elsewhere. Also because of the stigma attached, the man could not tell his boss that he needed leaves for infertility treatment, and there are no specific leaves for such a purpose.
- One male respondent's father is upset when he gets to know that *his son* could not have children as he always thought that his *son was the ultimate* in the world.
- The woman does not get as much support from the family for treatment as do men get.

Women's socialization A woman says that it is humiliating for men to undergo infertility related tests this, is seen as being against masculinity. She also assumes that few men could have such a problem. She feels obliged that her husband has supported her treatment and also gone for his own tests. Another female respondent could not tell others that she does not have any problem, but her husband is the cause of their infertility. She is willing to take the blame, and the couple does not reveal the truth.

Facilitator's feedback

The resource person highlights some of her main conclusions from the gender analysis framework (discussed in session 13 earlier during the course).

- The bargaining power of the wife increased if the problem is found to be with the husband. Women are seen to be upholding the religious practices to cope with the situation. Men coped by staying outside most of the time. They involved themselves more in their work.
- Some of the more striking revelations are related to the role of the health system. The researcher finds that the urologists do not make it mandatory for men to bring their wives but gynecologists ask women to bring their husbands.

  Urologists say that the if the men find out that they have some problem after the tests done , then they would not tell their wives about it and neither go with them for treatment.

Ensuring rigor in qualitative research: She explains a validity process in which more than one person codes the same transcript.

- Continuously going through data gathered to find gender differences in it.
- Then researcher needs to put data in the form of gender analysis framework.
- The present study enumerates the gendered nuances that affect individual ideologies on parenthood and the mechanisms of seeking treatment and coping. It attempts to bring forth salient gendered aspects at the level of cultural norms and expectations, access to and control over resources, and the bargaining positions of women and men in urban middle class culture.
- The gender analysis framework was used to understand the subtle aspects of involuntary childlessness and infertility and to understand the various relationships between gender and different variables.

Analyzing FGDs

- With respect to FGDs, the researcher can make a frequency table. The table would show that, for instance, if 20 FGDs are conducted then how many groups express similar opinion; whether the opinion is the majority opinion, though it is not as if the minority opinion is any less important.
- Such a procedure makes the analysis transparent and confirms that the conclusions that the researcher is drawing, emerge from what people have said.
- While writing about the FGD, in the discussion one could say that "Most people said…" and "Some said…." One cannot give percentages about how many people said some thing but can say that "Most (15 out of 20) said that….", and thus show how often an idea/opinion is expressed. No question/aspect of the research tool should be left unanswered. If the respondent is reluctant to answer a question, then that should be mentioned in the transcript.

Key points

The 'must' for analysis:

- Data should be legible, sensible, complete.
- Background information of participants provide important variables in analysis.
- Objectives should be clear and analysis should be in line with the objectives and the conceptual framework.
- Preparation is very important, pre-formulated categories should be listed down the researcher should be open and to add on categories or sub-categories.
- Establish inter-coder reliability to increase trustworthiness of the coded data.

Readings

1. Mathew B. Miles and A. Michael Huberman, An Expanded Source Book: Qualitative Data Analysis: A Sage publication.
2. Health Canada. (2003, June). *Exploring Concepts of Gender and Health (Chapter 3: Key Concepts in Gender-based Analysis).* Ontario: Women's Health Bureau, Health Canada, pp. 8-9.
3. Grant, K. R. (2002, Winter). *Gender-based Analysis: Beyond the Red Queen Syndrome.* Centres of Excellence for Women's Health, Research Bulletin, Vol.2, No. 3, pp. 16-20.

Based on the session developed by Bhamini Mehta .

Session 21: Managing Data and Writing Reports

Learning Objectives

Participants will be able to:

- Describe key steps in management of data
- Describe the essential components of a scientific research report

Methodology: Presentation

Time: 180 minutes

Activity

1. Presentation on Management of data

The facilitator starts by asking the participants what kinds of data they have handled. The participants may have experience of using qualitative and quantitative as well as secondary data. The facilitator points out that secondary data can be used only if it is managed well and is user friendly. She states that managing the data starts right from the beginning of the study and not after data collection is done.

Some common problems in data

- A lot of information is collected. One should remember the implications of collecting too much data - more resources are required, how is it going to be used, etc.
- Volume of raw data is large.
- Uniform way of recording data is not maintained. This happens more so in qualitative data, in quantitative data it happens when the data is open ended.
- All the raw data is not transformed into usable form. For example, the number of households contacted to get less than one year old children to find immunization status is often not recorded by investigators; so it

is not known that those children are from how many households/population. This happens mainly with qualitative data. Even in quantitative data, everything might not get coded if one has not planned it well in advance.

- Failure to record all the data for example, Some times if there is delay in writing down the responses investigator relies on memory, then minute information may get lost.

Characteristics of good data set

- Data is easy to use.
- Documentation is clear and easy to understand, that is, how the data is coded and maintained.
- Users are able to access the dataset with relatively little start-up time.

Ensure….

- All the information required for the study has been collected in a standardized way.
- Unnecessary data that will never be analyzed is not collected.
- Procedures for management of data are planned in advance.

Management of data

Planning for the management and data collection is critical. Some issues are:

- File structure (assumption is that data is being transformed into computers)- What is the data file going to look like; How will it be organized; What is the unit of analysis, for example, is it 'household' or 'women', this should be known from the beginning depending on the objectives of research; Will there be one long data record or several smaller ones?

- Naming conventions-How will file and variables are named?

- Data integrity - In a qualitative research one might be interviewing doctors, paramedics, also doing secondary data analysis-how would these different data be integrated. Also, how will data be converted into electronic form? Checks need to be put in place to find

  - Invalid values, for example, answer code is 3 when options were only 1 or 2 for M/F

  - Inconsistent responses, for instance, a woman reports that she is a housewife and in next question some income is reported for her. Assumption is that housewife would not have any income, so need to check back in data whether actually woman has some income or it is misreporting.

  - Incomplete records. Missing data can be the result of unanswered question by the respondents. (Then need to say that data is 'not available' or if data is not applicable to that respondent then say 'not applicable'), investigator did not record, or the date entry operator missed entering.

- Preparing dataset documentation: What will the dataset documentation look like; what information will it contain?
- How will it be produced; who will produce it; will someone translate in the field itself; how will it be coded;
- Variable construction: this is important for data entry and analysis. what variables will be constructed following the collection of the original data; how will these be documented.
- Some other issues to be considered are: What steps will be taken to document decisions taken as the project unfolds; how will information be recorded on field procedures, coding decisions, variable construction which programmes will be used for which tasks?

The facilitator explains that Sometimes projects go on for a long time especially the intervention projects. Meanwhile the staff in the project often keeps changing. If the variables are not defined properly in the

beginning, or documentation is not done properly, then comparing the baseline data collected earlier and the end line data would be difficult for another person to do.

Using integrated software

- Variety of programmes makes data entry a lot easier.
- Soft ware for data entry-Spreadsheet packages, Access, MySQL, Oracle etc.
- Most large-scale data collection involve computer data entry.
- Carry out data integrity checks as the data are entered and create programming statements.
- A good data-entry programme will recognize automatic skips and fills, filling in missing data codes in intervening fields as appropriate.

Need to check data for

- Wild codes (like the example of code 3 given earlier when options were 1 or 2 for M/F) and out-of-range values.
- Consistency checks-requires knowledge of the substantive task at hand.
- Record matches and counts.
- Names of variable - **Question numbers:** Name variables corresponding to question numbers, for example, Q1, Q2a, Q2b. Q*n*. This has the advantage of relating directly to the original questionnaire but disadvantage of not being easily remembered.

  - **Mnemonic names:** Names chosen to represent the meaning of the actual variable. Some advantages are that they are recognizable and memorable. Disadvantages are that what is an "obvious" abbreviation to the person who created it may not be obvious to a new user. With limited number of characters to work with, it is not easy to create names with immediately recognizable referents. Also it is difficult to maintain consistency

across variables that share common content, for instance, always to use ED for education.

- **Prefix, root, suffix systems**: To think of each variable name as containing a root, possibly a prefix, and possibly a suffix. For example, all variables with education have the root ED. Mother's education would then be MOED, father's education would be FAED. Suffixes are often used to indicate data in longitudinal studies, the form of a question, or other such information.

Codes and coding

- Code categories should be mutually exclusive, exhaustive, and precisely defined.
- Identification variables: includes a study number and respondent number.
- Each interview response should fit into one and only one category.
- Preserving original information: for example, age-do not code it right away because one never knows for what kind of calculation one may need data at what stage.
- Open-ended questions can either use a predetermined coding scheme or the researcher can review the initial survey responses to construct the categories that emerge to ensure all the data is being transformed.
- Series of responses: Organizing the responses into meaningful major classifications is helpful. Responses within each major category can be given the same first digit. The second order or secondary digits can represent another category or be used to distinguish the specific response within the major category. This type of coding scheme permits analysis of the data in terms of broad groupings, individual responses or categories.

Facilitator introduces participants to the ATLAS package for qualitative data analysis. In case of manual analysis, investigators are asked to leave a wide margin and alternate lines blank. In the margins, codes can also be written. Different coloured highlighter pens could also be used to do colour coding.

Steps to lessen the incidence of error while creating data files

- Use a data-entry programme that is designed to catch typing errors.
- Consider double entry as is done in NFHS.
- If cost and time are limiting factors then carefully check the first 5 to 10 percent of the data.
- Separate the coding and data-entry tasks as much as possible so that same person does not do both.

Management of qualitative data demands

- Advanced and more detailed preparation for filing notes, regular feedback on field notes, translation from local language to English such that nuances are not missed while translating.
- In gendered research the researcher should be familiar with a gender analysis framework and accordingly make the categories to analyze data correctly...
- Type and nature of analysis intended, to be decided before hand.
- Proper checks during and after data collection.
- Using it most effectively in preparing report.

Difficulties in using computer

The facilitators says though computers make data management easier, they cannot collect, translate, code or interpret data, neither improve its quality. Other difficulties associated with using computers-

- Computer software demands text in English.
- Field notes written in local language need to be translated in English.
- Entering and repeated proof reading of the text is time consuming.
- Immediate feed back is not possible.
- Indexing/coding of text in programme format is often difficult and time consuming.

To analyze open ended and close ended questions

Open-ended questions need to be coded and are difficult and time consuming to analyze. There could be variation in interpretation of open ended responses by different researchers. The advantage is that the researcher can go in-depth using open-ended questions, which also enable collection of sensitive data. They are used in situations where one is trying to capture what one does not know much about, to get the 'why' of a situation, for example, "why are children not going to school?'

Close-ended questions are easier to collect, record, enter, analyze and they do not require any re-coding. Their disadvantage is that they give limited responses. Therefore they are used to collect such information for which the researcher knows that there are only limited responses like sex, religion, caste, source of drinking water and so on.

2. Presentation on Writing Reports

- The formats for thesis and dissertation would be different as prescribed by each university.
- For writing references each journal has its own pattern.
- Key contents of a good report are

  Executive summary
  Background or introduction
  Objectives of the study
  Methodology: Design, sample size, implementation
  Findings
  Discussion and Policy implication
  Lesson learned

Possible steps for scaling up or enhancing utilization.

Common mistakes in writing a report

Common Mistake # 1 - too lengthy and descriptive

Often length of reports is more than 100 pages.

- Contains unnecessary details and repetition.
- Ideally length of a report should not be more than 35-40 pages including tables, figures and appendices, for it to be read by policy makers and others.

Common Mistake # 2 - Disproportional allocation of pages to different sections/chapters

- Lengthy introduction.
- Short or vague description of methodology.
- Long description of findings.
- Short or no discussion on findings, lessons learned, suggestions for creating condition for scaling up.

Suggested Distribution of Report Length

There is NO fixed guide line

A report of 40 pages could be divided as

○ Title page, content, executive summary	10 %
○ Background, context and objectives	15 %
○ Research methodology	10 %
○ Findings	35 %
○ Discussion	15-20%
○ Lesson learned	5-10%
○ Recommendations for Scaling up	5-10%.

Common Mistakes # 3 **- Presentation *and description of findings from tables***

- Inappropriate table titles
- Figures given in 2 decimal points
- Figures not adding to desired number (100%)
- Describing all table figure in text
- Same findings given in table, text and figures

Example of unnecessary description

The facilitator gives an example of unnecessary description in a text. The facilitator points out that the italicised portions are unnecessary details that can be done away with.

> *'The end-of-project survey collected information on marital status of all household members aged 15 years and above.* Table 2.4 shows the percentage distribution of household population by marital status classified by age and sex. Among male aged 15-19 years, only four percent are currently married *while the rest 96 percent were unmarried.* Among the females 12 percent were married *while the rest 88 percent were unmarried.* The proportion of never married reaches very low among men by the time they reach the age of 30, while in the case of women, that stage comes by the time they reach the age of 25. *The proportions of divorced, separated or widowed were 1.7, 0.9, and 1.1 respectively.* Among the older age group more women were widow than men. The percentage of such women in the *age group 59-64, 65-69 and 70 + were 6, 13, and 21 respectively.'*

Common Mistakes # 4 - Presentation of charts and figures

- Complicated and difficult to understand
- Difficult to read (font size problem)
- Use of three dimensional figures
- Inappropriate titles

Considerations in Using Figures

- Position the chart in text where you refer it.
- Give a clear label on what the diagram shows.
- Choose the type of chart which best explain your findings.
- Clarity of the chart in explaining the findings and not the look, should be the focus.

Common Mistakes # 5 - Lack or Inappropriate statistical analysis

- Too often analysis confine to description of percentages.
- Lack of use of even common tests like Z- test, t-test, X2 test.
- Often use of "significantly different" without any statistical test are misleading.
- Use of sophisticated tests without understanding and/or interpreting the findings of analysis.

Common Mistakes # 6 - Interpretation and use of qualitative data

- Lack of understanding how quantitative data could be used to strengthen findings from qualitative data or
- Generalization and subjective use of qualitative data.

Common Mistakes # 7 - Lack or inappropriate interpretation of the findings

- Reports end with description of findings with no or inappropriate interpretation and discussion.
- Findings are not linked and interpreted in the social context of the setting.
- No discussion on programmatic / policy implications.
- Recommendations not based on findings given in text.

Common Mistakes # 8 - No description of

- Lessons learned and
- Recommendations for scaling up.

Common Mistakes # 9 - Style of report writing

- Use of tense and reporting in first person.
- Repetition of arguments and findings.
- Lack of logical flow in paragraphs and presentation of findings.
- Lack of clarity of what message actually the report should provide.

Common Mistake # 10 - Cover Page and Executive Summary

- Lengthy project title.
- No date and year of publication.

Executive summary should comprise of

- Background information
- Objective of the study/ Research questions
- Methodology
- Project intervention / activity
- Key results
- Lesson learned and
- Recommendations

Length of executive summary should not be more than 2-3 pages. There are different styles of writing executive summary- it could be written in continuous paragraphs, or in bullets with explanation of sub-heads. Inclusion of some bar graphs makes the executive summary interesting and useful.

Concluding the presentation, the facilitator says that report should be planned well:

- Be clear what message one wants to give.

- Be strategic in what one wants to achieve.
- Use correct format, layout and structure.
- Use correct tense.
- Give proper titles to tables and charts.
- Interpretation and discussion should keep context in center.
- Write a comprehensive executive summary.

Key points

- The formats for thesis and dissertation would be different as prescribed by each university.
- If time permits, getting one's report reviewed by one's colleagues would be very useful. Giving it to an outsider might also be helpful from the editorial point of view, but that person might not be familiar with the issue.
- For writing references each journal has its own pattern. Depending upon for which journal one is writing one should write references.
- A report for funding agency should be written according to the funder's requirement. One way could be to send an 8-10 page report of key findings at each step with a detailed report being sent at the end of the project comparing baseline, midline and end line statuses.
- One has to be clear about what data one needs, which will collect the data and why one is collecting that in order to be on track. Do not collect unnecessary data, which is never going to be analyzed.
- Everything, methodology, data presentation, coding style, etc. has to be planned in the beginning only.

Based on the session developed by Sandhya Barge.

Session 22 Applying Gender Research Methods: Researching Men

Learning Objectives

Participants will be able to:

- Recognize how sex and gender affect health of both men and women.
- Recognize how construction of masculinity impacts on men's health.
- Identify gender differentials in prevalence/incidence, treatment seeking behavior and consequences of certain health problem.
- Describe the essential components of a scientific research report.
- Undertake research on men related issues of health, for example, STDs/ RTIs/HIV/AIDS, Violence against women, mental health, road traffic accidents, and sexuality.

Methodology: 1. Group Exercise 2. Presentations of Participants' studies on Men

Time: 180 minutes

Activity

1. Group Exercise

Participants are divided into four groups and each group is given a fact sheet and a set of questions to be answered on the basis of the fact sheet. The fact sheets are on the following four themes:

a) Gender and Road Traffic Injuries
b) Gender and Mental Health
c) Gender, Health and Work
d) Gender, Health and Alcohol Use

The fact sheets are from WHO Department of Gender and Women's Health and provide global data. The participants are asked to answer the questions in the context of India.

Group 1 - Gender and Road Traffic Injuries

Questions to be answered

1. Explain the nature of the gender differences that emerges from the fact sheet for youth and elderly.
2. Explain the role of gender roles in injuries and masculinity as health hazard.
3. What are the gender differentials with relation to accidents vis-à-vis relation to exposure to driving, alcohol use and pedestrian behavior?
4. What are the gender differences in treatment seeking behavior?
5. What are the suggestions for further research? How relevant are the suggestions for further research for Indian context?
6. Would you like to suggest other themes or research questions?
7. What are the policy recommendations? How adequate are the policy recommendations?
8. Would you like to suggest additional policy measures and preventions programs keeping India in mind?

Group 2 - Gender and Mental Health

Questions to be answered

1. What are gender differences in prevalence, onset and course of disorders?
2. What are the underlying factors for mental health problems?
3. What are the gender differences in health seeking behavior?
4. What are the gender differences in service delivery issues?
5. What are the social consequences of mental health problems?
6. What are the suggestions for further research? How relevant are the suggestions for further research for Indian context?
7. Would you like to suggest other themes or research questions?
8. What are the policy recommendations? How adequate are the policy recommendations?
9. Would you like to suggest additional policy measures and preventions programs keeping India in mind?

Group 3 - Gender, Health and Work

Questions to be answered

1. What are the nature of the gender differences that emerges from the fact sheet with regard to men's work and women's work?
2. What are the various dimensions of gender differences that are related to occupational health?
3. What are the health implications for women?
4. What are the health implications for men?
5. What are the legislations and policies that had been recently legislated in this regard?
6. How relevant are the suggestions for further research for Indian context?
7. How adequate are the policy recommendations?
8. Would you like to suggest other themes or research questions?
9. Would you like to suggest additional policy measures and prevention programs keeping India in mind?

Group 4 - Gender, Health and Alcohol Use

Questions to be answered

1. What is the extent of problems related to alcohol use?
2. How do gender norms influence alcohol use?
3. What is the relation between alcohol use and risk behavior?
4. What are the acute adverse consequences of alcohol use?
5. What are the suggestions for further research? How relevant are the suggestions for further research for Indian context?
6. Would you like to suggest other themes or research questions?
7. What are the policy recommendations? How adequate are the policy recommendations?
8. Would you like to suggest additional policy measures and preventions programs keeping India in mind?

Each group makes its presentation and there is discussion on the contents of each fact sheet and the group's presentation.

2. Participants' Presentations

- Participants who have been doing research on men are asked to make presentations of their work related to the issues discussed during the session and highlight the gender issues.
- The task of the other participants is to analyze the study from the perspective of gender and rights. After each presentation they have to comment on how gender and rights are reflected in the study and how could these be enhanced.
- The facilitator encourage the group to think about whether the presented studies with men reinforce existing gender inequalities or are aimed at bringing about change. In other words, are they gendered studies or gender-neutral studies with men?

Facilitator concludes by saying

Gendered research studies on men would be based on gender analysis framework. They would examine how gender norms, gender roles, access to and control over resources influence what is being studied. How do the concepts of masculinities and power interact with phenomenon being studied?

Readings

1. 'Masculinity and Gender Violence' Gender Issues Fact Sheet No. 5.

Based on the session developed by TK Sundari Ravindran

Session 23: Ethical Issues in Conducting a Research Study

Learning Objectives

Participants will be able to:

- Describe steps in conducting ethically sound research

Methodology: 1.Small group exercise 2. Presentation.

Time: 90 minutes

Activity

1. Small group exercise

Participants are divided into four groups. Each group is given one research problem for which they have to say that if they are to take up that research problem then what would be their major concerns? For instance:

- Who would be the players in the entire research scenario?
- What could be the methods/ 2 best methodologies?
- What is the community setting that you would be working in?
- Any practical problem that you think you would face in taking up this particular research problem?

Group - 1

Research problem

Blood samples to be drawn as part of the household health surveys to arrive at HIV/AIDS prevalence and Hb levels.

Ethical Issues

After receiving participants' responses the facilitator puts forth her points-

What is the relevance of doing such a study?

A lot of such work being done in the country, is actually not relevant. Because international funding agencies are supporting certain sectors the work is going on. It would be unethical to use public funds for a study, which does not have any use/relevance. The funds being used for such studies are all public funds- whether Indians' or Americans'.

Group - 2

Research problem

Community based qualitative study to understand domestic violence that women are subjected to.

Ethical issues

Confidentiality of information, anonymity of respondents, role of investigator- would it be advocacy based, scope of the study. Related issues are how the findings are going to be used-is the study only for academic purpose or would there be practical application of the information collected.

Participants' Response

What would be the safe guards in case a respondent breaks down or gets traumatized during the interview; the researcher may also get traumatized. How would these issues be handled? It is also pointed out that many times if a battered woman speaks about her experience then she becomes more vulnerable, so her safety is a concern. Also if the researcher is to realize that a respondent is being beaten then what would be the responsibility of the researcher? Will the researcher take some action or not? For instance, in the case of anaemia, participants had earlier said that IFA tablets would be given, what would the researcher offer in this situation?

Facilitator's Response

- Is it the researcher's responsibility to provide health care? In fact giving IFA tablets is also not seen as part of the research team's work. If it is found that a woman is a victim of violence then does the researcher have a system in place where the woman's problem could be addressed?
- The consent given by gatekeepers should never be treated as the consent of potential research participants.
- Vulnerabilities of the participants in the research could be arising from structural, situational and biological factors and the researcher should be conscious towards them. For example, if an organization has been working in an area for a long time then the community people in that area would tend to feel obliged and may not be in a position to say 'no' to the researcher from that organization. It would have to be made sure that people are not consenting under any kind of pressure.

Group - 3

Research problem

To know users' (women, women seeking some specific health care) perspectives of quality of health care received.

Concerns

- Researcher needs to capture women's perspective, so the designing of the research should go beyond regular studies. The resource person says that most of the researches are done in slums because it is assumed that people there have spare time. Not being concerned about the people's time, researchers go to the slum. Since most of the research organizations are urban based it is convenient to conduct studies in urban slum.
- Major concern would be the willingness of women users to give answers about what type/quality of health care they are receiving.

There is a lot of social threat in case of problems like STDs and abortion.

- Are norms of quality of health care as defined by women and as defined by researchers the same?
- If a follow-up study is needed then it may be difficult to interview the same women.

Group - 4

Research problem

To know abortion and abortion care services from women's perspective.

Concerns

- With respect to unmarried women:

  - Willingness of the women to respond.
  - Protecting the women's identity.
  - Availability of abortion services.
  - Accessibility- whether unmarried women can get the abortion done.

- With respect to married women forced by the family to go for sex selected abortions.

  - Difficulty in collecting data- People may not be willing to give information if they have got sex selective abortion done.

2. Presentation - 'Doing ethically sound research'

The resource person begins the presentation by looking at some of the *characteristics of relationships* between parents and children, teachers and students, and employers and employees.

- Levels of formality: Relationships vary in terms of levels of formality in them. These levels change with time and place.
- Structured nature

- Content
- Power imbalances: Power is involved in every relationship.
- Stakes and risks: For example, employee would have more at stake as compared to employer.

Facilitator says that because there are the above dimensions in a relationship, certain norms and code of conduct are expected in each relationship. These norms/codes would have variations according to the culture and context. The norms are not static but dynamic and may change with time.

She asks, if and how, when, and why could there be violation of these. She gives some *historical examples* from both biomedical and social sciences, of the violation of such norms:

- Nazi regime and biomedical research
- Tuskegee/Syphilis progression
- Stanford Experiment
- Project Camelot- During U.S. insurgency in Chile, the social scientists lost their autonomy. They were being directed by the State about what should they be doing.

What triggered bioethics (1960s)

- Opening up of once-closed professions to public scrutiny. Medical profession starts subjecting its community/members to scrutiny by others.
- Development of liberal individualism – Focus on rights and autonomy forcing paternalism to recede. Most of the literature in bioethics is full of informed consent. This has a lot to do with political ideology that is prevalent in west from where ethics began.
- Development of new biomedical technologies that brought new ethical problems, for example, there are limited resources to put patients on dialysis. So everyone cannot be provided the service. How would then it be decided who would get the treatment.
- Renewed interest of philosophers in applied/ normative ethics.

- Concerns about research with humans
- Turning away from religious debates to secular ideas.

Ethical Issues in conducting a Research

Questions prelude to conducting any Social Science Research.

- Why should I take up this topic for conducting a research? What new knowledge would it generate?
- Who should be my respondents?
- Why do I choose to make them my respondents?
- Would my research undertaking make any difference in their lives?
- How do I go about conducting this research?
- What is the best/good/desirable way?
- What kind of problems would I come across- before and during data collection, while processing it?
- When/Why does an Ethical dilemma arise?
- When does it become necessary to make choices in how to go about doing a research? In a situation involving value differences, where a researcher has to decide between two or more equally attractive or unattractive alternative courses of action

What are Ethics?

- A branch of philosophy in which Moral Values are examined.
- Concerned with the conduct of human beings.
- What ought to be done in a given situation.
- The 'Oughtness' is coloured by values believed to be 'Good' in a society.
- So what we value as Good will determine what we consider to be Ethically Good.
- Decision making about achieving good in a situation.
- Self-regulation, Conscience checking.
- What ought to be done is not necessarily what is easiest, efficient, effective, or economical.

What are Ethical Principles?

- Principles are rules or standards for good behavior.
- Ethical principles inform moral choices, help guide discussion moral problems.

Moral Principles for Ethical Research

1. Non- malfeasance: no harm causing.
2. Beneficence: Positive contribution towards welfare of participants & society.
3. Autonomy: Respect and Protect rights and dignity of participants.
4. Justice: Fair distribution of benefits and risks.

Ethical Principles for Social Science Research

1. Essentiality
2. Maximization of public interest and social justice
3. Knowledge, ability and commitment to do research
4. Respect and protection of autonomy, rights and dignity of participants
5. Privacy, anonymity and confidentiality
6. Precaution and risk minimization
7. Non-exploitation
8. Public domain
9. Accountability and transparency
10. Totality of responsibility

Ethical Guidelines Based on Rights

- Rights of Participants
- Rights and Responsibilities of
    1. Researchers and Institutions
    2. Peer Reviewers/Referees
    3. Editors and Publishers
    4. Funding Organizations and Sponsors

Setting up Mechanisms

- Institutional level
- Team level
- Individual/Researcher level

Key points

- Gender, rights and ethics go hand in hand.
- ETHICS could be understood as 'Code of Conduct'.
- All relationships in any profession are governed by certain norms fairly accepted by the community.
- Researchers are a community and as a community they are expected to abide by some standards-rights perspective, gender perspective.
- Thus research ethics refer to a certain set of standards that the researchers do not want to compromise.

Readings

1. Bandewar, S. (n.d.). Cultural Barriers, 'Competence' and Informed Consent in Population-based Surveys. Research Ethics.
2. Abraham, L. (n.d.) Ethical and Methodological Conflicts in Sexuality Research.
3. Patil, R.R. (n.d.). Research in a Tribal Community. (Case Study)
4. LaPlante, P. (n.d.). Purity of standards: At What Price? (Case Study)
5. Saha, S. (n.d.) Challenges in Research in Tribal Communities. (Case Study)
6. Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women. WHO.
7. Ethics in Social Sciences and Health Research: Draft Code of Conduct.

Based on the sessions developed by Bhavna Mehta and Sunita Bandewar

Session 24: Review of Module 2

Learning Objectives

The participants will be able to:

- Clarify their doubts related to the concepts included in this module
- Identify how the various concepts are related

Methodology: 1. Questions and answers 2. Quiz

Time: 90 minutes

Activity

1. Facilitator starts by asking participants to list questions that they may have based on the contents of the module. Other participants are encouraged to answer these questions. The facilitator then summarises the responses.
2. Through a quiz, the facilitator promotes a recall of the concepts covered in Module 2.

Module 3

Taking Research Forward: Communication and Advocacy

Learning objectives

1. Know strategies for communicating research results to relevant audience, formats and media for disseminating research results, and writing for journals.
2. Know how to use research findings for program designing.
3. Describe the nature and types of advocacy, necessary and sufficient conditions for successful advocacy efforts.
4. Evaluate advocacy strategies from a gender and social perspective.
5. State/explain the various campaigns and need-specific advocacy strategies.

Session 25: Communicating Research

Learning Objectives

The participants will be able to:

- Describe and use strategies for communicating research results to relevant audience
- Develop formats and media for disseminating research results

Methodology : 1. Presentations 2. Discussion on participants' questions 3. Group Exercise

Time : 60 minutes

Activity

1. Presentation

The resource person starts by asking the participants 'what is good reading according to you?' S/he builds on their responses through the following presentation.

- Communication strategies must become an integral part of the research right from the beginning. The writing up of the project is usually done at the end and only by a certain person(s) in the project. Every research project must also have a writing plan on how the writing will be integrated in the project as well as who will be writing. The writing plan must begin ideally at the time of planning the project.
- The research project may be divided into five phases and the writing output for each phase may be planned accordingly. In the first phase of

the project, the writing output could be an exploratory article or essay on the field of study.

- In the second phase of the project, the output may be a literature survey paper based on the review of literature done as part of the research project or compiling a paper of abstracts.
- In the third phase of the project, during the process of data collection, the output may be in the form of feature writing on a particular area, or people or incidents, taking care of various ethical and copyright concerns.
- In the fourth phase, besides the research report, one could write spin off papers or presentations, press notes on the research (interview and be interviewed by the press), and organize book material.
- In the fifth phase, for the post project period, one can decide how many academic papers to write for the entire project, how many feature or popular media articles to write, whether these papers can form a book and whether the research report can be converted into a book.

The presentation is followed by a discussion on participants' questions related to writing.

2. Presentation on writing tips for press Notes and Feature Articles

- **Press Notes: Tips for writing**

Press notes are sent to media on research outcomes, findings, events, etc. A press note must be information rich. It should be concise, compact, limited to 200-300 words. It has to have a 'news' perspective, so that the journalist may find interesting concepts to publish in the newspaper or magazine. Press notes can be issued or sent to the press before or after the event.

While writing a press note,

1. Start with a paragraph, two or three sentences, which make a reader want to continue to read.

2. Put all the important information in the middle or the core of the note. For instance if one is reporting on a workshop, then one can put the important views expressed by people at the workshop, including direct quotes, in the core of the note.
3. Include relevant names and additional information, to enable the journalist to contact you for further inquiry.

3. Feature Articles: Tips for writing

Feature articles are a good format to communicate research outcomes. Feature articles give the researchers an opportunity to communicate their research finding(s) or their observations during research to a readership that might never see an academic research report. The following must be taken into consideration while writing a feature:

- Whatever the topic find a news peg for your research. A news peg means something that is topical, something related to the research, e.g. World AIDS Day.
- The introductory paragraph of a feature is not a summary (unlike in the case of academic papers/journal articles) but an invitation to read further. So the most interesting point should be highlighted in the introductory paragraph.
- Readers like information, but not as 'information'! Information should therefore be provided in attractive ways, in quotes, and figures, translated into everyday terms.
- Respect for the reader, there should be no 'talk down'.

4. **Group Exercise: write a Press Note:** The participants work in groups to write press notes. Each group presents their press note to a panel of Editors of newspapers, who are volunteers from among the participants. This panel as well as the resource person gives feedback on the press note.

Media Rules: Some Dos and Don'ts for Writing

Vision Thing

- ***It is important to ask: Who am I writing for? Why am I reporting this research? How will it affect the issue/people that I am writing about? Who will benefit from it directly, indirectly and inadvertently?***

Fairness

- ***Stop, look and listen to all sides, even if your research material is on only one aspect. This is what provides the grounding for the article, locates it in a relevant perspective, and even makes it lively.***

Responsibility

- ***Don't cover up unpalatable truths, even if they do not support your main hypothesis or finding. The exceptions are important. E.g. in your study of impact of mill closures on women, you find that because of this event women are now seeking and finding new and better paying jobs elsewhere. Will you write about it?***

Don't wave the red flag!

- ***Don't exaggerate or moralize***
- ***Your writing should speak for itself. You don't need to underline the facts or keep pushing your particular ideological or political perspective.***
- ***If economic liberalization has had a negative impact on women's work in a particular situation, show it; don't wave the anti-liberalization flag.***
- ***Refrain from polemical writing.***

Source: *Adapted from Kunda Dixit's Dateline Earth: Journalism as if the Planet Mattered.*

Based on the session developed by Padma Prakash

Session 26: Writing for Journals: A view from the Editor's desk

Learning Objectives

The participants will be able to:

- Describe what constitutes a good academic paper
- State important tips to increase the likelihood of their research/manuscript being published

Methodology: Presentation and discussion

Time: 120 minutes

Activity

1. Presentation

The presentation by the resource person covers all the important stages and steps in writing a good academic paper, starting from conceptualizing the paper, identifying potential publishers, to structure and contents of a good paper. The presentation also discusses referencing and avoiding plagiarism.

- ***Before the writing***

One must start thinking about writing a paper at the beginning of the project, make a note of possible target publications and research them.

Choose a topic that will continue to engage your attention throughout the exercise. Ask yourself: Why am I writing this paper? It is important to have fun while writing.

Keep a diary and make note of other ideas for writing as one goes along. It is important to keep a note about one's experience, people one may need to meet again and of course the reference material that is needed for the paper.

Researching the target publication is important so that the paper can be made relevant to the subject matter and style requirements of the publication. Examine its archives to see if anything similar (as the planned paper) has appeared in the past. Make a note of change in content trends, if any.

Get a toehold in the journal. This can be done by writing a discussion note or a letter to the editor, or offering to review a book related to the current research project. The aim is to establish a line of communication.

- ***Writing the paper***

Prepare an Outline

- Write a 100-200 word pre-draft summary of your paper. This can form the basis for your introduction.

- List out the subtopics – this is an aid to help you focus on the theme and subtopics which are not important to the construct of the paper finally.
- List the subsections under each of the sub-topics. It is useful to prepare a bibliography of each subsection. In a data based paper, list out what elements of the data analysis you will use in this particular subsection. Remember in a completed paper the sub-topics may run across the paper. The subsections are the mechanical devices for organizing the paper.
- Start filling out the subsections.
- Organize the subsections in a logical order so that one flows into the other.
- This will give you the core of a rough first draft. Add the introduction and the conclusion at this stage.
- Continue to revise the outline even while you fill out the subtopics or subsections. It may undergo a complete change by the time you finish. It is just a devise to help organize your paper.

Plagiarism: Know it, Spurn it

- Forms of Plagiarism

    - Downloading paper from the web and submitting as your own
    - Copying from earlier coursework by someone else
    - Cut and paste jobs from the web
    - Quoting less than the full quotation
    - Faking a citation

- Detecting Plagiarism
    - Mixed citation styles

    - Lack of references
    - Skewed formatting, anomalies of diction, - sudden sophistication, anomalies of style
    - Datedness
    - Resources on the web to check if the paper has been plagiarized.

Plagiarism can be avoided by understanding what referencing is all about.

[Taken from *Robert Harris 'Anti-Plagiarism Strategies for Research papers'.www.virtualsalt.com/antiplag.htm*]

Gender-Sensitive Language

- 'Inclusive' instead of 'exclusive' use: exclusive is words that by their form or meaning discriminate: for example, *craftsmen, weatherman, forefathers, gentleman's agreement.* Inclusive words instead of the abovementioned words are like, *artisan, meteorologist, ancestors, and unwritten agreement.* Also, *manufactured* instead of *manmade*; *average person* instead of *man in the street, maintenance hatch* for *manhole*, *and chair* instead of *chairman/chairperson*.

- Assumed gender – nurse or secretary are assumed to be a woman; and doctor, or pilot to be a man. e.g. "the surgeon put on his gloves".
- Gender in pronouns
    - Recast noun/pronoun in plural "as a doctor, he should..." to "as doctors they should..."
    - Delete pronoun altogether e.g. "a good health worker relies on ***his*** common sense." "A good health worker relies on common sense. ";
    - Replace masculine pronoun with an article; ***every*** trainee should bring ***his*** manual. to "every trainee should bring the manual"; and
    - Use first or second person instead of third person, e.g.: "a careful clerk checks ***his*** books" to "as a careful clerk you should check your books".

Readings

1. The writing of the Social Sciences, Sundar Sarukkai

Based on the session developed by Padma Prakash

Session 27: From Research Design to Program Design

Learning Objectives

The participants will be able to:

- use research findings for program designing
- apply the gender analysis framework to analyze programmers as well as the research design

Methodology: 1. Presentations of case studies 2. Discussion on applying gender analysis framework

Time: 120 minutes

Activity

1. Presentation

Invited resource people present their case studies of how different bits of research were the basis for the designing intervention programmes.

Key Messages

1. Research helps in finding out the gaps and where the program implementation is required. Research can also tell us about with what target groups we need to work with.
2. Research findings also work as a supportive document when one tries to convince some government or non-government agency for implementing any program.
3. Principles of using research for program design:

    - Every research report should include an action plan, or implications for action.
    - We need to articulate a clear perspective before beginning the research because it will influence the program designing.

- Operationalisation of terms is very important.
- Identifying different stakeholders is important.
- Stake holder analysis should be done to identify the parties that can help in a particular problem.

2. Application of gender analysis framework

The participants can be asked to identify gendered aspects of the research as well as the programme design in the case studies presented.

Readings

1. Empowering Non-Government Organisations to run emergency transport services, Tamilnadu, Clare Kitchen, ECTA
2. Janani Suraksha (maternal protection) Helpline, a 24 hrs emergency obstetric care telephone service launched on Safe Motherhood Day, Sandeep Biswas
3. Arranging Referral Transport in Emergencies, from MOHFW GoI, New Delhi, Maiti K D
4. (Original Query at the Solution Exchange for the Maternal and Child Health Community)

Based on the session developed by Archana Joshi and Shubhada Kanani.

Session 28: From Research to Advocacy

Learning Objectives

Participants will be able to:

- Define advocacy and types of advocacy
- Understand the relevance of research for advocacy
- Describe the process of using research findings for advocacy
- State the necessary and sufficient conditions for successful advocacy efforts

Methodology: Presentation

Time: 60 minutes

Activity

Presentation

1. Resource person asks participants to state what they understand by the term advocacy, five words that come to their minds when they think of ADVOCACY.
2. Resource person uses those words to define Advocacy.

A democratic tool to bring about change – social, political, economic.

Advocacy is an organized, deliberate, systematic and strategic process intended to bring about a positive change towards fulfilling, respecting, protecting and promoting human rights of marginalized individuals and groups.

Advocacy is about increasing the voice, access and influence of marginalized individuals and groups in all decision making processes that affect their lives, towards changing existing power hierarchies and relations.

3. Resource person asks participants what connection they see between Advocacy and Research.

- Research can contribute to advocacy in number of ways like in identifying core advocacy issues or 'problems' and possible solutions; by being an advocacy tool, by substantiating advocacy efforts with data/evidence.
- Research serves to

✓ Make visible significant issues to policy planners and implementers (through for instance, community-based research).
✓ Create recognition or awareness of the significance or prevalence or severity of a problem (through quantitative and qualitative research).

4. Resource person shares examples of how research in the area of women's health has contributed to advocacy.

a. The Jan Swasthya Abhiyan (JSA) or People's Health Movement conducted state wise survey to assess the situation of state health services and to document specific cases of denial. This was followed by a public hearing along with National Human Rights Commission (NHRC) at the state, regional and national level. Following this prompt action on specific cases to bring justice and provide compensation was undertaken by the state commissions. This also triggered a process of developing Public Health Acts in different states.

b. Implications of the two child norm on women resulting from the law barring persons with more than 2 children from holding elected offices in local self-government: The study by SAMA – Women Resource Group, New Delhi, in 12 districts of Madhya Pradesh and the analysis done by Nirmala Buch –

UNFPA in five states of India brought out the specific violations of the Act, particularly on women and the marginalized sections. Subsequent lobbying resulted in the revoking of the Act in Madhya Pradesh.

5. Resource person presents a framework for evaluating the advocacy efforts.

A Tentative Framework for Evaluating Advocacy Efforts

Constituency

- Who was the constituency?
- Was it part of the advocacy effort?
- Where was it at various phases?

Rights based Advocacy

- Did the advocacy effort address specific rights' violations?
- Was the advocacy initiative rights based in its approach?
- Did the power relations change as a result of the advocacy effort?

Research and Analysis

- Was adequate research and analysis built into the advocacy?
- Were the advocates able to project themselves as informed, authentic and authoritative?
- Was the analysis of the original issue accordingly reformulated in the advocacy?
- Was the campaigning sufficiently fine tuned and proactive with respect to larger macro changes nationally and internationally?

Long-term Sustainable Processes

- Was the advocacy effort able to create long term processes for continuing the work initiated?
- Were upward, downward and horizontal linkages created and sustained?

New Consciousness and Awareness

- Was the advocacy able to bring new consciousness among more and more people, media, and people in the judiciary/legislature/bureaucracy?

Gender Aspects

- How did the content and process of the advocacy effort see women and men? In stereotypical roles?
- What did it do address gender equations within the campaign and in the larger society with respect to the issue?

Readings

1. Advocacy: An Overview, Khanna R.
2. Advocacy: Issues, skills and systems. Unpublished manuscript, Srinivasan, S.
3. Dealing with Advocacy. A practical guide. (Hannover: RHI ComNet.), Van Kampen, J.

Session developed by Anuj Kapilashrami and Renu Khanna

Session 29: Advocacy Tools and Strategies

Learning Objectives

Participants will be able to:

- Design advocacy campaigns based on a research study
- Demonstrate the use of various tools and strategies for advocacy

Methodology: Group exercise

Time: 90 minutes

Activity

1. Participants are divided into groups. Each group is given one of the research papers/ reports that they have read earlier in the course. They are asked to develop an advocacy plan based on the following framework.

A- Situational Analysis (Factors)

- What is the political, economical and social context?
- What is the available evidence? Do we need to build more evidence?
- What are the rights violations?

B- Stakeholder Analysis (Actors)

- Who will support the advocacy effort?
- Who will oppose?
- What are the skills, resources available?
- What more is required?

C- Identification of Advocacy Issues

- What are the issues that need advocacy? What is the change you seek to bring about?
- Advocacy:

- To whom?

- By whom?
- For whom?

D- Planning strategies and activities

- Following are the principles of rights based advocacy.

- Refine information base.
- Develop communications.
- Balance consensus building, negotiation and confrontation.
- Make linkages across issues and groups.

E- Mobilization, Networking, Alliance building

- Who can be the allies? And for what?
- Who can be potential allies?
- What is required to bring them in?

F- What advocacy tools will you use?

- Press release
- Letter to the editor
- Posters
- Policy brief
- Pamphlet
- Signature campaign
- Others

Participants are told to remember that their advocacy effort will be evaluated using the framework described in the previous session.

2. Groups present and the other participants comment based on the Evaluation Framework.

3. Resource person summarizes

- As a researcher one may have identified the core problem or issue, identified a possible solution to the problem as well. What should one do as the next step? How does one put the findings to use? What is the larger aim of undertaking the research?
- One must have an in-depth understanding and clarity of the problem, its magnitude and severity, understanding of the existing policies and their implementation/non-implementation, the stakeholders, and the change required in legislation, policy, regulation, legal decision, committee action, institutional practice etc.
- To prove a point or argument, it is necessary to collect and disseminate evidence to substantiate the arguments and this can be done through research/ data gathering and analyzing. Secondary data can be used as an indicator, to prove or disprove, the arguments based on the data.
- Advocacy is an ongoing process rather than a single policy or piece of legislation. Planning for continuity means articulating long-term goals, keeping functional coalition partners together and constantly updating data and arguments. It is necessary therefore to evaluate outcomes. If desired changes occur, then the implementation of the advocacy strategy and action needs monitoring. If desired changes do not occur, the strategy or action must be reviewed and revised, and the advocacy process needs to be repeated accordingly.

Session developed by Anuj Kapilashrami and Renu Khanna

Session 30: Review of Module 3

Learning Objectives

The participants will be able to:

- Clarify their doubts related to the concepts included in this module
- Identify how the various concepts are related

Methodology: 1. Questions and answers and 2. Quiz

Time: 90 minutes

Activity

1. Facilitator starts by asking participants to list questions that they may have based on the contents of the module. Other participants are encouraged to answer these questions. The facilitator then summarises the responses.

2. Through a quiz, the facilitator promotes a recall of the concepts covered in Module 3.

SECTION III
Additional Readings

Additional Readings

Module 1: Introduction to Concepts and Tools in Gender, Rights, Development, and Health.

1. *A report on methodology workshop. Small grants programme on Gender and Social Issues in Reproductive Health.* January 5-7, 2003. Organized by Achutha Menon Centre for Health Science Studies, Trivandrum.
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What is Gender?

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Harvard Series on Population and International Health, Cambridge, Massachusetts.

Locating Gender Inequalities within Class and Caste

20. Liddle, J. and Joshi, R. (1998). *Daughters of Independence*: Gender, Caste and Class in India. (Chapters 6-10), pp. 49-83.
21. Bhopal, K. (2000). *Gender, 'Race' and Power in the Research Process: South Asian Women in East London (Chapter 5).* In C. Truman, C., D. Mertens, and B. Humphries (Eds.), Research and Inequality. USA and UK: UCL Press, pp. 67-79.

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